

Mad or bad?

Entry to the mental health system, from the courts.

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Tena koutou te whanau o nga hau e wha.

Greeting to the family (of readers) from the four winds.

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This thesis is dedicated to my father, and to my son.

ABSTRACT

This thesis is concerned with criminal defendants who become psychiatrically hospitalised as the outcome of their court proceedings. There are four routes whereby criminal defendants can become hospitalised in New Zealand. These are to be found not guilty by reason of insanity, to found to be under disability, to be found guilty and mentally disordered and for charges to be dropped and proceedings initiated under the Mental Health (Compulsory Assessment and Treatment) Act, 1992. The background to each of these options is explored, with an emphasis on the insanity defence, and the empirical literature reviewed. There are some theoretical contradictions in whether these legal provisions are therapeutic or punitive.

The aim of the current study was to describe criminal defendants who enter the mental health system and become psychiatrically hospitalised via the Court Liaison Service. The Court Liaison Service is a part of the Regional Forensic Psychiatric Service. As part of this service, a nurse screens criminal defendants at court for indications that mental health intervention may be warranted. A sample of defendants, who were seen by the Court Liaison Service at Christchurch, is described. Of these defendants some receive a full psychiatric evaluation and a report is prepared for the courts. The characteristics of those who receive a report are compared with those who do not receive a report. Defendants, who are hospitalised as an outcome of their court proceedings, are compared with those who are not.

The findings are consistent with international research, in that most defendants were male, and socially disadvantaged in a number of ways. The mental status screening assessment was a useful discriminator between those who received a report and those who did not, and between defendants who were hospitalised and those that were not. Most defendants who were hospitalised showed clear signs of psychotic processes. Defendants who received a report but who were not hospitalised are particularly vulnerable in terms of their mental health needs. This group showed more evidence of depression, and was rated to be of higher suicide risk. They

tended to have psychopathic traits, and were more frequently referred because of concerns about dangerousness. A considerable proportion of all defendants have difficulties with substance abuse.

Report and hospitalisation status could be effectively predicted, using information collected at the time of the Court Liaison screening. For example, using diagnosis and mental status data as predictor variables, there was 86% correct classification of cases as hospitalised or not.

In conclusion, it is argued that the insanity defence serves little current pragmatic use. Revision is recommended in the current admission criteria to psychiatric hospitals for criminal defendants, with an emphasis on effective treatment programmes. The victim's perspective is not frequently considered in deliberations about mentally disordered offenders, and this is seen as important. Finally, the Court Liaison Service serves an extremely valuable function at the interface between the criminal justice and mental health systems in New Zealand.

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CHAPTER ONE

INTRODUCTION AND LITERATURE REVIEW

1.1 INTRODUCTION

Words such as crazy, mentally ill, mentally disordered, and insane, tend to evoke powerful images, and emotional reactions in many people. So too with crime. This study concerns the nexus of mental disorder and crime. It discusses the interface between the mental health system and the criminal justice system, and those offenders for whom the social response to the breaking of criminal laws is that they enter the mental health system.

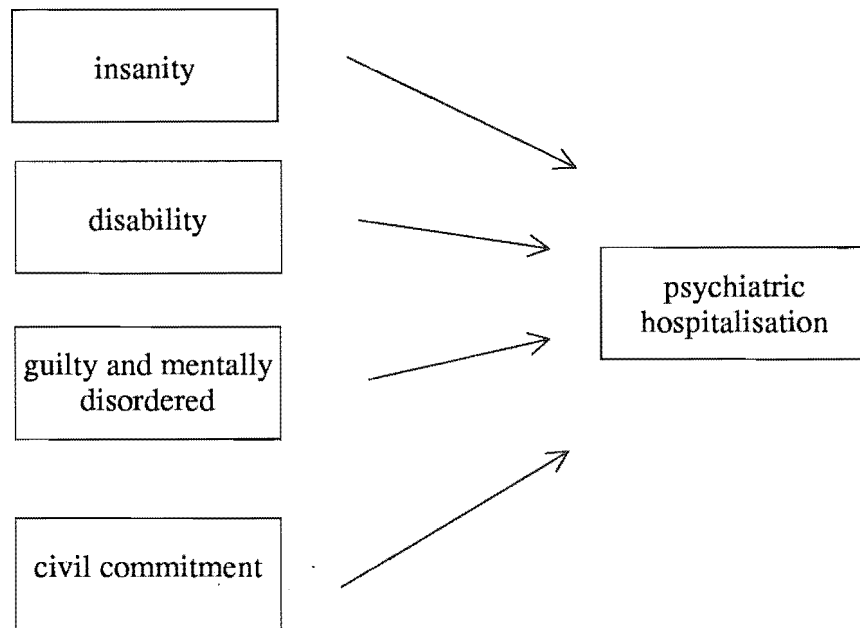
There are four ways, in which criminal defendants can become psychiatrically hospitalised as a consequence of their court appearance. These are to be found not guilty by reason of insanity, to be found under disability, to be found guilty and mentally disordered, and for civil commitment to occur, that is, the charges are dropped, and a compulsory treatment order made.

Despite its unfortunate connotations, Brookbanks (1996c) defines the word 'disposition' to refer to the manner in which an offender is dealt with by the courts, following a finding that the offender is mentally disordered, legally insane or otherwise unfit to be tried and sentenced. The four disposal options are shown in Figure 1.

Finkel and Fulero (1992) attempted to delineate the functions and values of the insanity defence in law. The first of these concerns culpability, in that, this verdict reflects a judgement with regards to the defendants blame worthiness. Secondly, in a related manner, is the conceptual function of the insanity defence in jurisprudential theory. It is seen as an essential element in justice, and in determining blame and justifying punishment. The insanity defence serves a dispositional function, in that it determines that some defendants are sentenced in the criminal justice system, and others enter the mental health system. The insanity defence also serves a symbolic function, reflecting to some extent and with questionable accuracy, society's position with regards the mentally disordered in the criminal justice system.

Figure 1

Admission criteria from the courts to psychiatric hospitals



There are other ways in which those who criminally offend receive therapeutic intervention. Sentenced offenders may be transferred from prison to psychiatric hospitals (s. 45 and s 46 Mental Health (Compulsory Assessment Treatment) Act, 1992). Community based sentences such as supervision, sometimes include conditions relating to interventions, such as psychological counselling. Other defendants have their charges withdrawn when they agree to attend a community treatment programme. These alternatives however, are outside the scope of the current study, which is focussed on criminal defendants who become psychiatrically hospitalised as an outcome of their court proceedings.

In chapter one, each of the disposal options is considered in turn, with an emphasis on insanity. Reference is made to relevant theory, and conceptual issues, history, legal standards, and empirical research findings. In chapter two, the context of the current study and the Court Liaison Service which is a primary focus, are outlined. Wade (1992) first referred to the 'gate keeping' function of the Court Liaison Service, in that it is a point of entry to mental health

services, for criminal defendants in New Zealand. The rationale and the aims of the study and a description of the methodology that was used follow this. Chapter three reports the results. In chapter four five illustrative case studies are described, and in chapter five the results are discussed and their implications considered. The study questions the current pragmatic utility of the insanity defence as an entry point to the mental health system, finds victims needs poorly considered in cases of mentally disordered offenders, and identifies a group of defendants, described as 'the vulnerable', who have important mental health needs.

In this thesis, the following abbreviations are made. The Criminal Justice Act, 1985 is referred to as CJA, 1985. The Mental Health (Compulsory Assessment and Treatment) Act, 1992 is referred to as MHA, 1992. The option described as guilty and mentally disordered, is referred to as a section 118 CJA, 1985 hospital order, because this is the common usage. The Regional Forensic Psychiatric Service is referred to as RFPS, and the Court Liaison Service as the CLS. Reference to the Court Liaison Nurse is made by the abbreviation CLN.

The Southern Regional Health Authority, and the Human Ethics Committee, University of Canterbury granted the current study ethical approval.

1.2 INSANITY

1.2.1 Theoretical issues

Definitions

By its very nature crime is difficult to measure. It is usually not readily observable. Behaviours are regarded as criminal by reference to a legal code, and determining the existence of crime involves a negotiated process, between the rule violator and other parties such as the police and the courts. Definitions of crime change over time, such as with the temperance laws in New Zealand, and across cultures such as with homosexuality. Crime therefore can be regarded, at least to some extent, as a transitory social phenomenon reflecting the legal expression of moral values.

Determining an accurate definition, description, and understanding of the etiology of mental disorder, has also been problematic over time. Despite considerable medical and scientific progress over recent decades, there is no definitive answer with regards either what constitutes, or causes mental disorder. While Finkel (1988) attributed difficulties in operational definition to the open nature of the construct, Shea (1996) argued more strongly that terms like mental health, and mental illness, are in fact impossible to define, because they are socially and culturally determined, and involve both subjective and objective elements. Given the very nature of mental disorder, Shea has argued that no definition is acceptable in all countries, or applicable in all settings, and that never will be. As the authors of DSM-IV (American Psychiatric Association, 1994) have indicated, even the word 'mental' is problematic, in that it implies an artificial distinction from physical disorders.

Wakefield (1992) argued that the term 'disorder' refers to a harmful dysfunction, and because the evaluation of harm is based on social norms, the determination of mental disorder, at least in part, is a value judgement. Commonly used classification systems, such as the DSM-IV and ICD-10 (World Health Organisation, 1992), seek to provide comprehensive coverage of all the conditions, for which help is sought from mental health professionals, which has led some authors to suggest that mental disorder is any condition which professionals treat. Other

conceptualisations of mental disorder have viewed it as statistical deviation, emotional distress, maladaptive behaviour, and the violation of moral and ideal standards. None of these has proved sufficient.

Debate is also ongoing with regards the accuracy and usefulness of the DSM-IV and ICD-10. Neither provides a comprehensive definition of the term 'mental disorder', which is used rather than mental illness. When using these classificatory systems, the boundaries between disorders are not always as sharp and clear cut, as the classificatory systems suggest. The use of categories assumes that there are distinct boundaries between disorders, rather than reflecting the clinical reality, which is that frequently clients present with features of a range of disorders. Symptoms overlap between diagnoses, and with essentially normal functioning, and require careful clinical evaluation.

Part of the issue, is that decision making is made with reference to context, severity and impact on everyday functioning, and therefore is not absolute. It is not just behaviour, which is evaluated, but the circumstances and manner with which it occurs. Refusal to eat may be a reflection of a psychotic process, an eating disorder, or a person with no psychiatric difficulties who is on a diet, or simply not hungry. Many of the defining features of even severe disorders such as schizophrenia occur in 'normal' people during other times and circumstances, for example, during sleep and dreaming (Shea, 1996). Additionally Lipkowitz and Iduganti (1983) noted in the area of schizophrenia, that diagnostic labels are sometimes used by clinicians in idiosyncratic ways that do not reflect standard classifications. Thus the personality and functioning of the mental health professional may influence the conclusions that are reached.

Diagnostic labels tend to reflect little of the human experience of the person who has the disorder. Individuals who share a diagnostic label are not necessarily alike in any important way. Heterogeneity is a feature of most diagnoses, even to the extent of the features that define the diagnosis. Psychiatric illness is superimposed on a person's pre-existing personality, and personality influences the expression and clinical presentation of the mental illness.

Categories vary across time, and with new versions of classificatory systems, and do not necessarily equate. An example of this is also found in the area of personality disorder. An ICD-10 diagnosis of dissocial personality disorder is based on evaluation of personality characteristics, and does not equate with a DSM-IV diagnosis of antisocial personality disorder, which is operationalised in behavioural terms.

Part of the difficulty with the diagnosing of mental disorder is that there is no external criteria with which to establish validity. For example, there is typically no confirming biological dysfunction. In contrast to many physical impairments, where the validity of a diagnostic system can be established with reference to easily measured standards, mental health and disorder, remain essentially hypothetical constructs, that are difficult to measure. Not surprisingly, the reliability of diagnostic judgements has also been questioned (Kutchins & Kirk, 1986; Ziskin & Faust, 1988), and is not without difficulties.

Epidemiological studies typically confirm that mental disorder is frequent, amongst the general population (Wells, Bushnell, Hornblow, & Joyce, 1989; Oakley-Browne, Joyce, Wells, & Bushnell, 1989), and even more frequent, amongst offender populations (Brinded, Fairley, Malcolm, & Siegert, 1996). This implies that there are unlikely to be many important differences between those who suffer a mental disorder at some points in their lives, and those who do not.

The impact of labelling is relevant to mention, when discussing the definition of mental disorder. Even prior to assessment by mental health professionals, someone in the person's social environment or the person themselves, has noticed something, and made a decision to bring it to the attention of professionals. Others might have interpreted similar behaviour as odd or eccentric, their tolerance for dealing with unusual behaviour might be higher, or it might have been decided that it was not their responsibility to take further action. Once a label or diagnosis is assigned, future behaviour tends to be interpreted in accordance with the label.

Some circularity of argument is often involved with applying diagnoses, in that there may be confusion, between the diagnosis, and the explanation. For example a person who acts

strangely, might be given a diagnosis of schizophrenia, and when the question is raised as to why the person is behaving strangely, schizophrenia is given as the explanation.

Finkel (1988) has been critical of what he has referred to as psychiatry's claim to sole expertise in dealing with aberrant behaviour, and viewed this as evolving from the medical disease model. The advent of this model was attributed to the early Greek physicians, who reacted against older animistic ways of understanding mental disorder, where spirits, demons and gods, were viewed as responsible for mental disorder, by arguing that biological defect or illness were more realistic causes. While medical progress in some areas, such as the treatment of syphilis in the early 1900s, and the efficacy of psychotropic medication in treating some forms of mental disorder, has been remarkable, it has also become clear over time that factors other than biological ones, such as learning and environment, have important roles to play in understanding the etiology of mental disorder. Well known critics, such as Szasz (1974) have referred to the manufacture of madness, and the medicalisation of problems in living. He has regarded diagnoses to be essentially evaluatory labels, that justify the use of medical power to intervene with regards behaviour that is socially disapproved of. However, despite its historical origins, most current conceptualisations and assessments of mental disorder, involve the consideration of biological, psychological, social and cultural factors.

Converging disciplines

A diagnosis per se, or the presence of mental disorder, does not equate with the legal concept of insanity, and in itself, yields little information about the matter on which the court must decide. Mental disorder is, however, a necessary component of insanity. Insanity is determined by considering the crucial issue of, the extent to which the mental disorder impacts on the specific abilities that are relevant to the legal issue under question. As discussed below (chapter 1.2.4), for the insanity defence to succeed in New Zealand it must be shown that the defendant was suffering from a disease of the mind, to such an extent that the individual was incapable of understanding the nature, and quality of the act, or of knowing that it was morally wrong. Even if a very severe mental disorder was apparent, the insanity defence would not be applicable, unless it

was demonstrated that the disorder had a major impact on either the persons capacity to understand the specific act being considered by the courts, or that it was morally wrong. What is important, within the legal context, is the severity of the mental illness, the degree of impairment, and the impact that it had on thinking and behaviour. Thus while mental health professionals have a vital role to play in determinations of insanity, the ultimate determination of this issue remains within judicial parameters.

In unravelling what Finkel (1988) has referred to as 'the gordian knot of insanity', he discussed the historical relationship, and 'courtship', between the disciplines of law, and psychiatry and psychology. They are distinctly different, in some fundamental matters, yet both are involved in the determination of legal insanity. Moreover, there is as yet no clear specification of the relationship, or easy correspondence between their respective frameworks. These disciplines work together, on a case by case basis, but there are also wider issues with regards the foundations of law, and the social sciences. Traditionally jurisprudence has focused on interpreting past law, and analysis of doctrinal consistency within the law. It thus has an internal focus, in contrast with the social sciences, which examine the relationship between law, and behaviour, or the law and other outside forces. Social science theorising therefore is external to the law.

From the perspectives of psychology and psychiatry, mental disorder is best viewed as existing on a continuum of severity, but the law is more absolute. There is no doubt clinically that there are varying degrees of mental abnormality, yet the extent of severity which is sufficient to meet the legal meaning is unclear. Legal decisions with regards the presence of mental disorder are essentially threshold judgements. In some circumstances the presence of psychotic processes are sufficiently severe to warrant the insanity defence, and in others they are not. The threshold does not relate to disorder type, and there is no clear-cut line that delineates the degree of necessary severity. The wide variability of individual behaviour and circumstance ensures the complexity of the issue.

Mackay (1995) has argued that decision points must also be identified on the continuum construct of responsibility. A core issue is whether the mental illness was of sufficient severity, to render the person not responsible for their conduct. The question as to whether a person clearly understood the wrongfulness of their behaviour, and was therefore responsible for it, is not answered by the term 'psychotic'. The link must be made between the psychosis and the defendant's judgement. Judgement itself is not a unified trait, and its aspects take many forms. With some mental disorders, such as organic impairment, it is clear that judgement is grossly impaired. It can be argued that the thinking and judgement of someone with depression is also faulty. However, an insanity defence would be unlikely to succeed on this latter argument. People can think clearly and rationally, in some aspects of their lives, yet be very impaired in others, and judgement involves a process of evaluation over time.

An additional issue is that psychiatrists and psychologists giving evidence in court work mostly from a nomothetic model. The basis of these disciplines is empirical research studies, which most frequently focus on groups of individuals, who are similar in some manner, and compared with others who are different. The law in insanity cases is dealing with individuals, and is therefore ideothetic. It seeks a causal link between impairment and behaviour. A mental health expert in court, crosses from the nomothetic to the ideothetic, and inferences are made about individuals based on class membership. Probability statements can be offered to the court, based on empirical evidence, or clinical judgement, but there can be no certainties with regards a particular individual. There is no proof of underlying illness or its connection to culpability.

Morality and punishment

Mackay (1995) argued that the core issue in insanity determinations is deciding whether, as a result of insanity, the person is much less responsible than normal, so that it is just to treat him as wholly irresponsible. After reviewing the work of various legal and philosophical scholars he proposed that it is the absence of capacity for rational conduct that underpins the concept of legal insanity. From this perspective, rationality equates with normal mental functioning, and society expects individuals to share, at least to a minimum practical extent, a background of basic perceptions, values, skills and attitudes. Moore (1984) in his discussion of morality, argued that only if we can view a person as acting to achieve a rational end, in the light of fundamental beliefs, that we use to understand ourselves, and others in everyday life, do we regard them as moral agents. He referred to rationality as 'practical reasoning', and believes that society operates, because individuals can interact with each other on this basis. Likewise, Lipkin (1990) has proposed that responsibility signifies that the person's behaviour satisfies a particular societal conception of this process.

Rudick and Levy (1994) reported a theoretical analysis of the link between personality disorder, and criminal responsibility, using Moore's formulation of rationality, practical reasoning, and causal agency. A person with schizophrenia may believe that some higher power is commanding him, and making him act in a certain manner, and this is essentially irrational. In contrast, the psychopath is motivated by selfish aims, that are however, essentially rational. They concluded that because the behaviour of people labelled as psychopathic is not inherently irrational, they therefore should be held accountable for their actions.

An underlying philosophical issue, in this area, is the free will versus deterministic debate. At the extremes of this continuum, the deterministic position is that every action is completely determined, whereas the free will stance holds that individuals are completely free to choose their actions. Law presumes that people have free will, whereas much of the work of social sciences reflects a deterministic position. Rychlak and Rychlak (1990) concluded that there is as much theoretical and empirical justification for believing that people have free will, as there is

for denying this capacity. As Finkel (1988) has pointed out, however, both of these metaphysical doctrines lead to the same conclusion, that it is impossible to distinguish those acts freely carried out, from those that are not, and any attempt to do so must lead to error. While the law makes differentiations of this nature, they are justified by reference to the morality of the ordinary man or woman, rather than any metaphysical position. MacKay (1995) considered that scholars from both stances agree, also that some people do suffer from mental disorders of sufficient severity that they ought to be excused from behaviour that would otherwise be regarded as criminal.

Criminal law, however, essentially regards individuals to be moral agents, who are capable of making free choices as to how they behave. The imposition of sanction by the legal system is justified with reference to moral blameworthiness. With the insanity defence, mental disorder impairs an individual's cognitive abilities, to such an extent, that they no longer have free choice, and are to be pitied rather than punished. Behaviour that is subject to criminal sanctions results from free will, whereas behaviour that results in a successful insanity plea is not. Szasz (1983) argued that the greatest harm done by mental illness, is the loss of free will inherent in the label. While a person may suffer immensely from unfair criminal conviction, for Szasz this suffering is less philosophically, than the loss of the essence of humanity, which accompanies the loss of free will.

The social response to crime is determined by considerations of causality. If a criminal code is broken, and this is viewed as being because of a lack, or impairment in morality, the person is punished. Society's judgement is critical and negative, and the person is viewed as bad, or even evil. If, however, the act is viewed as arising from an inner defect or illness, the social response is therapeutic intervention, and society is more benevolent, and arguably paternalistic. The person is to be excused because they are mad. Western society almost universally considers it unjust and immoral, to punish those who have been found to be legally insane. If a person cannot comprehend the behaviour that they have committed or that it is wrong, there is no basis for punishment. MacKay (1995) has questioned the basis of this. While the argument is based on the belief, those who are unaware of what they are doing, cannot be deterred by criminal

sanctions, there is no empirical evidence to verify this. While the threat of punishment may be ineffectual, its actual infliction may have more, less, or the same impact, compared with those who are legally determined to be culpable. Discussion of the circumstances of hospitalisation, below (chapter 1.2.9) makes it clear that there is often a punitive element involved in compulsory hospitalisation, particularly when it is for an indefinite period of time.

A critical viewpoint

The Metropolitan Toronto Forensic Service (METFORS) is a Canadian multidisciplinary agency, established during 1978, with the purpose of assessing potentially mentally disordered defendants. Menzies (1989) traced the institutional careers of a cohort of 592 men and women, referred to METFORS by following their medical and correctional records, from the time of initial arrest, through their assessment, legal proceedings and decision making, through to follow up two years after initial contact. As a consequence of this investigation, Menzies questioned the politics of knowledge and power, during the entire process, whereby the State determines that defendants are mentally able to stand trial. He portrayed the pre-trial psychiatric assessment, as extending legal and therapeutic control over those defendants suspected of mental illness. It was argued that both the nature and quality of forensic psychiatric activities reflect the expectations of legal officials, with whom they frequently interact. The credibility of forensic clinicians is determined, at least in part, by their value and medical expertise in legal forums. Clinicians seek to maintain this authority, however, legal standards for assessing medical decisions are virtually non-existent. While the psychiatric assessment is relatively detached from the legal process, forensic clinicians are viewed as primarily legal actors, who have similar allegiances, morals, and beliefs, to other actors, including the police, lawyers, and the judiciary. Forensic clinicians adopt a legalistic perspective, however, in contrast with other legal professionals, they use the medical model as the legitimising ideology. Psychiatric diagnoses and medical practice are used to justify the decisions that are rendered to the court, and the credibility of forensic clinicians is maintained by the legal relevance of these judgements.

Menzies (1989) argued that the psychiatric assessment process is essentially moralistic in nature. He views psycholegal decisions, as being moral ones that are presented as statements of fact. Forensic assessment involves conceptualisations of good and bad, normal and abnormal, and invariably locates the causes of criminal behaviour within the individual. During assessment virtually every aspect of the defendant's life, is open to scrutiny by experts, and information is selected which fits often preconceived, notions of the defendant's character. The focus is on pathology, and human variation is interpreted from this focus. The manner in which decision-making is reached is inconsistent and unclear, however, labels are assigned and the defendant's history and current behaviour, viewed in the light of these labels. While the aim of this process is to increase communication and understanding, there is virtually no challenging of this process, and the defendant is rarely given the opportunity to offer alternative explanations. Because the knowledge of clinicians is elite knowledge, in that it is not part of everyday speech, the professional activities that it justifies, and the decisions that it authorises are not open to non-specialists, particularly the accused person. Once a label is attached to a person, it tends to be reproduced in future documentation with regards that individual, and becomes selfvalidating. Personal identities, and the human experience, are lost. Psychiatric judgements and decisions, are rarely challenged in court, and labels such as 'dangerous', or 'personality disordered', provide justifications, within the legal system, for the imposition of further punishment. Clinicians essentially manufacture formal knowledge that enables coercive control by legal authorities. Thus the legal system, and the forensic assessment service, are interdependent, and work in such a manner, that they justify each other's processes and decision making.

Because of this legal perspective, there are limitations on the questions that are posed when assessing a case, and the creative solutions that are sought. Menzies (1989) was critical, of what he viewed as a move away from democracy, and the full and real involvement of the defendant in the assessment process, so as to best foster justice and human potential. He claimed that people repeatedly leave the clinic in a worse position than when they entered, in terms of their personal identities and prospects for future positive life development. Menzies argued that

the METFORS should be closed, so that problems can be viewed more clearly as residing within systems, as well as within individuals, and so that clinicians are not compromised by being both in a therapeutic and punitive role.

Victims

Victims hold an essentially unheard voice, in considerations of social responses to the offending committed by mentally disordered offenders. While it is clear that many victims of crime, suffer severe and long lasting consequences (Harland, 1995; Lurigio, Skogan, & Davis, 1990), there is no evidence that this is any more or less so when the offender is mentally disordered. It would seem unlikely, for instance, that a victim of rape, would be any less distressed, if an offender carried out this behaviour under the influence of hallucinations and delusions, than if he did not. Indeed, the very nature of psychosis, may make the act more bizarre, and frightening, for the victim and his or her family and friends.

New Zealand studies have confirmed that victims are no more punitive, than non-victims are (Lee, 1994). They want justice to be done, and to be believed and validated, and for the offender to be rehabilitated. Zehr (1990) described victim needs to include compensation, answers and information, so that victims can regain a sense of security, expression and validation of their experience of the offence and their emotional response to it, and empowerment in terms of a sense of personal power over their environment. Shapland (1985) reported that, while victims do not necessarily want decision-making powers, they generally would like to be consulted, specifically about issues such as decisions to prosecute or divert offenders.

Both research endeavours and theoretical critiques have largely ignored the perspective of the victim, when considering mentally disordered offenders. It is unclear why this situation has evolved, but it is likely that it has been justified with reference to the need to protect mentally disordered offenders, somehow, being paramount to the needs of the victims. This has a paternalistic theme that requires challenging from a more feminist and victim orientated perspective.

Summary

- (1) *Constructs such as crime, mental disorder, and insanity involve social, cultural and moral judgements, and there are no perfect definitions.*
- (2) *While mental disorder does not equate with legal definitions of insanity, it is a prerequisite.*
- (3) *There are some conceptual difficulties in the meeting of the social sciences and the law, for determinations of insanity.*
- (4) *The insanity defence is used within the legal system, to define the limits of free will. It serves a function in terms of justifying the imposition of punishment on those that are found guilty.*
- (5) *The work of Menzies (1989) has demonstrated how knowledge can be manufactured during forensic assessments. It has emphasised the personal human experience of the individuals involved.*
- (6) *The perspective of the victim is rarely considered when the offender is mentally disordered.*

1.2.2 History

The New Zealand legal system is based on its English heritage. The notion that some groups of people, particularly children and the insane, may not be responsible for their actions, can be traced back to ancient Greek and Hebrew civilisations (Platt & Diamond, 1966).

In pre Norman England, the secular law was based on collective responsibility, and strict liability for unlawful behaviour. Social responses were based on the principles of compensation and retaliation, without the concept of blame. Victims sought retribution, and an offender or their family, were bound to compensate for loss or harm. One difficulty with this system, was that some crimes, for example, murder or rape, are not easily able to be compensated for, and there was little justice in repeating an abhorrent act in a return manner. Injury was seen to occur not just to the victim, but to the 'King's peace and public order' (Platt & Diamond, 1966) and thus over time, the State became the central claimant in disputes and wrongdoing.

Ecclesiastical law and Christian canons as developed by the Church, and the medieval Universities, existed separately alongside secular law. It was concerned with the idea of individual conscience in determining culpability for sin, and consideration of inner states was important in determining moral guilt. By the thirteenth century, ecclesiastical and secular law gradually became integrated, and the long-standing principle of English law that crime consists of two components, criminal act (*actus rea*) and criminal intention (*mens rea*) became established. To be guilty of a crime and eligible for punishment, it had to be shown that an identified person carried out the illegal act or admission, and that the person had the state of mind proscribed in relation to the crime. It is noteworthy that even at this early time, there was concern with the cognitive aspects of mental state in determining responsibility, such as intention and recklessness, and not with the emotional aspects of human functioning.

There were many different formulations of responsibility and the treatment of the insane over the next centuries. The law developed in an erratic manner that Gunn and Taylor (1993) referred to as 'human and pragmatic'. A series of trials in the eighteenth century, however, underlie the current approach.

The first of these was in 1724, when Edward Arnold shot and wounded Lord Onslow. It appears that Arnold suffered from paranoid delusions, and the court instructed that for a man to be acquitted on the grounds of insanity, he must be:

“totally deprived of his understanding and memory and does not know what he is doing, no more than an infant or a wild beast, such a one is never the object of punishment.”

(Walker, 1968, p.56)

This was the so called, ‘wild beast’ test of insanity. Quen (1981) pointed out that, the term ‘wild beast’, at that time, referred to animals such as rabbits, fox, and deer, and not the violent, wild and ravenous image, that has been associated with this test. What was important was the lack of understanding.

In 1800 James Hadfield attempted to kill the King. Hadfield had been brain-injured during the Franco-British wars, and subsequently developed delusions. The importance of this highly publicised trial was that following a finding of not guilty due to insanity, he was sent to Bethlem Hospital. Prior to this time, it was usual for the family to gain custody of insanity acquittees. The trial marked the beginning of medical input, into legal decision making with regard to insanity. Insanity acquittees, regarded as dangerous, and in need of confinement, were not entitled to release (Finkel, 1988).

The trial of Daniel McNaughten in 1843 was pivotal in the history of the insanity defence. It occurred against a background of political, economic, and social upheaval. McNaughten shot and killed the Private Secretary to the English Prime Minister, Robert Peel. McNaughten had confused Drummond and Peel, and believed that the Prime Minister was plotting against him. Medical evidence clearly indicated that the shooting was the result of a psychotic idea of reference, and McNaughten was acquitted of the crime, and committed to Broadmoor Hospital. The acquittal raised a public outrage, to which the Law Lords of the English House of Lords responded to by clarifying the legal position. The formal test of legal insanity became:

“It must be clearly proved that, at the time of committing the act, the party accused was labouring under such a defect of reason, from disease of the mind, as not to know that the nature and quality of act he was doing; or if he did know it, that he did not know that what he was doing was wrong.”

(Moran, 1981, p.173)

It must be established that, in addition to defect of reason, or disease of mind, the defendant did not know the nature and quality of act, and that it was wrong. Thus it contained a strong cognitive emphasis.

By the 1860s, the M'Naughten rules were firmly established in English common law, and were rapidly accepted in most American States. Criticisms however, soon arose from both legal and medical arenas. These focused on the restrictions of this insanity test, to cognitive issues and thought processes. As Ogloff, Roberts, and Roesch (1993) have pointed out, sometimes people can know something intellectually, without really appreciating its implications, or internalising the knowledge.

In response to this, the irresistible impulse rules with their focus on volitional controls came to supplement the M'Naughten rules in many United States jurisdictions. Under this standard, it became possible to be acquitted on the grounds of insanity, even if a defendant knew the difference between right and wrong, if as a result of mental disease, ‘their free will was so destroyed, or overwhelmed, that the defendant lost the ability to choose between right and wrong’ (Finkel, 1988). With the exception of the State of New Hampshire, the M'Naughten rules, sometimes in conjunction with volitional control tests, dominated United States federal and State legal standards, until the 1960s.

The New Hampshire product test, introduced during 1954, was a controversial response to criticisms with regards ‘total’ incapacity. Advances in the study of personality were also influential, in that increasingly human functioning was viewed as an ‘integration of multiple, interacting levels of cognitive, affective, and motivational functions’ (Golding & Roesch, 1987). According to this standard, a person was not criminally responsible, if the unlawful behaviour was the ‘product of disease or defect’ (Ogloff et al., 1993). The use of this standard led, however, to

unanticipated consequences. Mental disease was equated with any diagnosis, and the test tended to become a medical rather than legal one. There were also considerable difficulties with expert testimony. Eventually the product test was replaced with the American Law Institute (ALI) standard, which is discussed below (chapter 1.2.3).

In discussing historical perspectives of the insanity defence, it is also relevant to mention the use of the insanity defence in the Soviet Union, as it was applied to political activists. Halpern (1991) reported that, prior to 1987, dissidents were often found not guilty by reason of insanity, after a court hearing at which they were not present. These people were then hospitalised in special forensic hospitals, for an indefinite period of time, and refused release, even when hospital psychiatrists and officials recommended discharge.

Summary

- (1) *The concept of insanity has evolved over time, albeit slowly. This reflects the social and open nature of the construct.*
- (2) *Collective responsibility for crime has been replaced by individual responsibility.*
- (3) *The M'Naughten rules are the basis of the current New Zealand legal standards with regards to insanity.*

1.2.3 International Perspectives

England

In England and Wales, the M'Naughten rules are incorporated in the Criminal Procedure (Insanity and Unfitness to Plead) Act, 1991. This Act was introduced to allow for flexible disposal options. Following a finding of insanity, defendants may be admitted to a psychiatric hospital, with or without a restriction order, a community supervision order may be made, or an order for guardianship, and there is the possibility of absolute discharge.

Only a small number of defendants, however, are detained under the provisions of this Act. Gunn and Taylor (1993) suggested that at least part of the reason for this is the difficulty with interpretation, and the strictness of the M'Naughten rules. Most offenders are dealt with under the provisions of the Mental Health Act, 1983, which outlines the procedures for compulsory assessment and treatment in England and Wales. Anyone 'suspected, charged or convicted of a criminal offence' may be detained in a psychiatric hospital under this Act.

America

Each State and federal jurisdiction specifies in its criminal laws the relationship of mental state to criminal responsibility. A verdict of not guilty by reason of insanity is possible in all States, with the exception of Idaho, Montana and Utah, which do not have an insanity defence (Callahan, Mayer, & Steadman, 1987), and in all federal jurisdictions. Those States that do not have the insanity defence rely on guilty but mentally ill provisions, and the mens rea element of defence. In 26 of 47 States, the M'Naughten standards are used while the ALI standards are employed in the remainder (Harding, 1993). The ALI standards state that:

"A person is not responsible for criminal conduct if at the time of such conduct as a result of mental disease or defect he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law."

(s. 4.01 ALI, 1962)

There is specific exclusion of those whose mental disease or defect is manifested by repeated criminal conduct. The ALI standards contain the notion that cognitive or volitional impairments, as a result of mental disease or defect, may provide justification of acquittal on the ground of insanity. Important differences in comparison with the M'Naughten standard, are the requirements of substantial, rather than total incapacity, and replacement of the concept of 'to know' with 'to appreciate'. This suggests a component of affective, as well as cognitive understanding.

In the district of Columbia, the ALI standard was employed when John Hinckley Jr was acquitted on the grounds of insanity, for the attempted murder of President Reagan (Low, Jeffries, & Bonnie, 1986). The public controversy which resulted has been compared with that at the time of M'Naughten, and led to a number of reforms that are contained in the Comprehensive Crime Control Act, 1984, which refers to federal jurisdictions. The volitional component of the ALI rule was eliminated, and the standard is therefore, substantially like M'Naughten, with a cognitive emphasis.

"The defendant, as a result of a severe mental disease or defect, was unable to appreciate the nature and quality or wrongfulness of his acts."

(s. 20 (a) US Code, Title 18)

This legislation removed the modifier 'substantial', with reference to capacity to appreciate, and reintroduced the earlier and arguably obsolete notion, of total deprivation of capacity. It also reversed two important trends, described by Brakel and Cavanaugh (1996). Antisocial personality disorder had been gradually accepted in some jurisdictions, as the requisite mental disease or defect, that qualified for the insanity defence, however, because the definition emphasised 'severe' mental disease or defect, those with personality disorders and emotional difficulties, were clearly excluded. Whereas, before this Act, there had been a steady expansion of psychiatric participation in determinations of insanity, the revisions that accompanied it specifically disallowed mental health expert witnesses to comment on the ultimate issue of the defendant's sanity.

If a defendant is found not guilty by reason of insanity, he or she faces a commitment hearing, to determine the involvement of the defendant within the mental health system. Involuntary hospitalisation, for an indeterminate period of time, is a possible outcome, as is mandatory outpatient psychiatric treatment.

A number of special defences have been attempted in various American jurisdictions, over recent years with varying degrees of success. These have included posttraumatic stress disorder, XYY abnormality, battered woman syndrome and multiple personality disorder (Bartol & Bartol, 1994). Defendants have been absolved of criminal responsibility on the basis of the severity of these conditions, and they have been successfully used to support claims of diminished responsibility.

Australia

The state of Queensland has unique and innovative legislation, under the Mental Services Act, 1978-1987, such that a Mental Health Tribunal, while having criminal jurisdiction, yet divorced from the atmosphere of the criminal court, decides matters relating to mental disorder and crime. The tribunal is made up of a judge of the Supreme Court, advised by two psychiatrists. When there is reason to believe that a defendant, who has been accused of an indictable offence is mentally ill, or was so at the time of the crime, the question of the person's mental state is referred to the Mental Health Tribunal. Proceedings are open to the public, and defendants may elect to go to trial, or appeal to the Court of Criminal Appeals, against the decisions of the Tribunal (Harding, 1993).

In New South Wales, criminal courts decide matters with regards to the insanity defence, and diminished responsibility. The Mental Health Review Tribunal, of New South Wales, an independent body, deals with management issues with regards to insanity acquittees, and those found unfit to plead. Review of each person, occurs at least six monthly intervals, and detention is contingent on determination that the safety of the patient, or any member of the public will be seriously endangered by the patient's release.

Other Countries

Canada follows a standard in the McNaughten tradition. Norway employs a so called 'biological standard', and is the only country in Europe that continues to do so. It needs only be established, that the person was insane at the time of the act and there is no requirement that a causal connection be demonstrated between the defendant's mental state and his or her illegal actions. Hoyer, Eaves, and Enwright (1995) compared the way in which the criminal justice systems in Canada and Norway, deal with insanity acquittees, and concluded that in neither country are substantial numbers of people found not guilty by reason of insanity.

Harding (1993) reported that, in Austria, Bulgaria, Denmark and Switzerland, which have criminal laws developed in the French tradition, responsibility is used to refer to both capacity to understand the unlawful nature of an act, and the capacity of control one's behaviour. Given a mental disorder, and the absence of one or both of these capacities, the defendant cannot be found guilty.

Similarities and differences

Within most jurisdictions of the developed Western world, it is possible to be acquitted from criminal charges on the ground of insanity. Most of the legal standards for insanity use the McNaughten rules as their basis, and challenges to this standard, as has occurred in some American jurisdictions, have met with only limited success. There is however, marked variability between jurisdictions, in the detailed specification and interpretation of these standards. With the exception of Queensland, the question of insanity is always determined within the criminal court. The percentage of defendants involved across jurisdictions is typically small. Many jurisdictions have developed further options, between the extremes of insanity and total culpability including unique defences, diminished responsibility, and findings of guilty but mentally ill. All jurisdictions seek the advice of mental health professionals to assist in determining this issue, however, there appears to be variability in the weighting that is given to this advice, and whether comment on the ultimate issue is permissible. Following determinations of insanity, there is typically the provision of mental health services in some form, and in many jurisdictions it is a point of entry into the

mental health system. There is however, variability between jurisdictions with regards whether insanity acquittees are managed within the criminal justice or mental health systems, and distinctly different decision making bodies are responsible for their management. It is rare for defendants who have been found not guilty by reason of insanity to be truly acquitted, in that there are no social consequences for their behaviour.

Summary

- (1) *Across all jurisdictions, the insanity defence typically applies to people who are psychotic.*
- (2) *Not all people with psychosis are found to be legally insane, in that the psychotic processes have to occur at the time of the crime, and impact on the individual's cognitive functioning.*

1.2.4 New Zealand Law

The M'Naughten Rules were first incorporated into New Zealand law in the Criminal Code Act, 1893. Currently, section 23 (2) of the Crimes Act, 1961 states:

“No person shall be convicted of an offence by reason of an act done or omitted by him when labouring under natural imbecility or disease of the mind to such an extent as to render him incapable

- (a) of understanding the nature and quality of the act or omission; or
- (b) of knowing that the act or omission was morally wrong, having regard to the commonly accepted standards of right and wrong.”

(s. 23 (2) Crimes Act, 1961)

As in the original formulation of the M'Naughten laws, the presumption is made in New Zealand law that everyone is sane, until the contrary is proven (s. 23 (1) Crimes Act, 1961). It is currently up to the accused to establish the insanity defence to the civil standard of proof, that is the balance of probabilities.

Brookbanks (1996b) has pointed out the main differences between the M'Naughten Rules and the legal definition of insanity in New Zealand. The New Zealand definition focuses on the defendant's capacity to understand, whereas the M'Naughten Rules are concerned only on the

defendant's actual knowledge. In New Zealand, there is specification that knowledge refers to the moral knowledge rather than legal knowledge, as has been proposed historically, and in some jurisdictions. Also, 'natural imbecility' is included in the New Zealand provisions, as a possible prerequisite in addition to 'disease of the mind'. This has been equated with mental retardation (Robertson, 1992), and refers to intellectual disability, either present from birth, or acquired through illness or trauma.

The phrase 'disease of the mind' is a legal concept, when raised as a justification for the insanity defence. It necessitates the involvement of medical witnesses, who give opinions as to whether a disease of the mind was present in a particular case and if so, its causes and symptomology. Dyer (1983) suggested that the inherent vagueness in this term has its roots in the keenness of the legal profession to retain responsibility for determination of this issue, rather than medical practitioners. The term is very general, states nothing about possibly relevant conditions and etiology and does not directly equate with 'mental illness', which within this context relates to a medical framework, rather than a legal one. From Brookbanks' (1996b) discussion of the relevant New Zealand case law, it is clear that psychoses are viewed as diseases of the mind. However, personality disorders are excluded, as are difficulties arising from self induced substance abuse, most anxiety disorders, and circumstances relating to human functioning and conflict, such as loss of control, or extreme anger outbursts.

Knowing the nature and quality of the act refers to the possibility that because of delusional processes, the defendant might not have conscious awareness of their situation or behaviour. If someone was killed, while a defendant clearly believed that he or she was under the control of some authority that had commanded this behaviour, it is likely that an insanity defence would exist. However, as both Brookbanks (1996b) and Goldstein (1988) have commented, this component of the insanity defence is almost never challenged in litigated insanity cases.

When the insanity defence is disputed in New Zealand, it is almost always with reference to the knowledge of the moral wrongfulness of the act. The courts, to refer to subjective knowledge have interpreted this strand of the definition. That is, while there can be appreciation

that acts, such as murder, are morally wrong generally, and that most people agree with this, a person can because of psychotic processes, believe that the specific act of them killing another person, was not morally wrong. Under the influence of delusions and hallucinations, they might view their behaviour as morally correct and justifiable behaviour, or even beyond moral judgement. While some critics have argued that this interpretation is beyond the statutory provision (for example, Adams, 1971), Brookbanks (1996b) has reported that it has still occurred. The justification that has been proposed for this is so that it reflects historical intent and tradition, and to bring under the provisions of the insanity defence a significant group of defendants who are clearly insane.

While insanity is a usually a *mens rea* defence, in that it involves the cognitive aspect of behaviour, an exception to this is the rare circumstance when automatism is raised as a defence. If an act is not voluntary, as in the case of automatism, the person is not viewed as causing it, and under the legal necessity of *actus rea*, the person is not viewed as liable. Brookbanks (1996b) proposed that, if the cause of the automatistic state was internal to the individual, as with psychosis or disorders such as epilepsy or arteriosclerosis, it would be viewed as a disease of the mind, and the insanity defence provisions would apply. If however, the etiology of the unconsciousness or dissociation, was external to the individual, for example, a blow to the head, or medication error, there would be no disease of the mind, and an outright acquittal could occur.

In contrast with some other jurisdictions, and with the arguable exception of the provisions relating to infanticide (s. 178 Crimes Act, 1961), neither diminished responsibility nor irresistible impulse, are current statutory defences in New Zealand. Case law authority has established however, that mental health difficulties, which in some manner are shown to diminish responsibility, can be used as mitigating factors in determining culpability, and to justify a reduction in sentencing.

The statutory provisions regarding the disposition of those found not guilty by reason of insanity, are found in section 115 of the CJA, 1985, which are interpreted with reference to the MHA, 1992. The CJA, 1985 states that decisions are to be made with reference to 'public safety'.

(s. 115 (2) CJA, 1985). An order can be made for the person to be immediately released (s. 115 (2) (b) CJA, 1985). This disposition is not frequently used however it may be appropriate when there is no public danger, and the offender is not likely to benefit from any form of treatment. If the offender is liable to be detained under a custodial sentence, as a result of previous or subsequent offending, it is possible that no order will be made (s. 115 (2) (c) CJA, 1985).

If there is little concern with regards public safety, an offender found not guilty by reason of insanity may be held in a psychiatric hospital, as a committed patient (s. 115 (2) (a) CJA, 1985) under the provisions of the MHA, 1992. While the CJA, 1985, states that the person is to be detained in a hospital, it is a clearly delineated principle of the MHA, 1992, that inpatient hospitalisation, is justified only when it is not possible to treat the person in the community (s. 28 (2) MHA, 1992). In effect, the person may be treated, either in hospital or the community, and decisions such as leave and release are determined by the persons' responsible clinician.

In cases where the court is satisfied that there is risk to the public, the defendant can be held as a 'special patient' in a psychiatric hospital, in secure conditions and under strict conditions of leave and release. Special patient status does not equate with any diagnostic category, or treatment, and is essentially politically determined by consideration of public protection. Offenders transferred from prison to psychiatric hospitals are also special patients, as are some of those found to be under disability. Indefinite detention is legally possible (s. 117 CJA, 1985) however, as Brookbanks (1996d) pointed out, regular clinical review, and review by the Mental Health Review Tribunal, at not more than six monthly intervals as provided for in the MHA, 1992 (s. 77 and s 80) means that this is unlikely. Ongoing detention is justified only in the person's own interest, or for the safety of the public (s. 80 (5) (a) MHA, 1992). Usually over time the person's status is changed to that of a committed patient, and they are gradually released into the community.

Summary

- (1) *The legal standards of insanity in New Zealand today focus on the presence of mental illness, which has impacted on the defendants ability to know the nature and quality of his or her criminal act, and that it was morally wrong.*
- (2) *Most of those found not guilty by reason of insanity are psychotic at the time of the crime, and are diagnosed with either schizophrenia or bipolar affective disorder. Antisocial personality disorder and substance abuse are clearly excluded.*
- (3) *A finding of not guilty by reason of insanity is an entry point into mental health system in New Zealand.*

1.2.5 Myths

Empirical myths

A number of commentators have discussed the public perception, and skepticism with regards the insanity defence. The role of the media in inaccurately informing the public is usually criticised. Media portrayals of cases where the issue of insanity is involved are frequently inaccurate, and there is selective reporting of violent, bizarre, and sensational crime rather than routine reporting (Silver, Cirincione, & Steadman, 1994). It appears likely that the media impact increases public fear about mentally disordered people, and increases negativity toward them.

Public opinion surveys in America have consistently shown that the public has limited or inaccurate knowledge with regards the insanity plea and its consequences. Often its frequency in criminal cases is overestimated. Pasewark, Seidenzahl, and Pantle (1981) reported that a community sample believed that 42.5% of those facing criminal charges plead insanity. Silver et al. (1994) reviewed the empirical studies in this area, and reported that overall, the public believes that 37% of felony indictments result in an insanity plea. In considering the actual volume of insanity pleas, across eight states of America, and with a very large sample Callahan, Steadman, McGreevy, and Robbins (1991) found that overall the insanity defence was raised in one percent of felony cases. Similarly, Pasewark, Jeffery, and Bieber (1987), found that in Colorado those found not guilty by reason of insanity were only 0.007% of total arrests.

McGinley and Pasewark (1990) conducted an American nation wide study, and reported that the insanity plea was rarely used in criminal trials. These authors commented also on the wide variation both in the actual number of insanity adjudications and the ratio of these verdicts to arrests, across States that occurs for largely unknown reasons. These authors surveyed 50 States and found that on average one insanity plea was made per 873 crimes, with the mean success rate of these pleas being one for each 6.5 pleas made. Rice and Harris (1990) concluded that there is general agreement amongst researchers, that the proportion of defendants found not guilty by reason of insanity is exceedingly small, and in most jurisdictions is under 1% of the cases dealt with by the courts.

When the insanity defence is raised, the public tends to overestimate its success considerably. Jeffrey and Pasewark (1983) using a community sample found that it was estimated that 45% of those that plead insanity are acquitted. This is similar to the rate of 44%, reported by Silver et al. (1994). Callahan et al. (1991) found that only 26% of those raising the insanity defence were successful, which again is similar to the rate reported by Silver et al. (1994). Clearly it is not an easy way out for those wishing to avoid criminal responsibility.

The public also believes that the insanity plea is frequently abused. Hans and Slater (1983) and Hans (1986), who conducted telephone surveys, reported that over 85% of respondents agreed with statements such as, 'the insanity plea is used too much', 'too many people escape responsibility for crimes by pleading insanity', and 'the insanity defence is a loophole that allows too many guilty people to go free'.

An early study by Steadman and Cocozza (1978) found that typically murderers or violent criminals were named as those likely to be found not guilty by reason of insanity. These results were replicated by Wahl (1990) however, as discussed in chapter 1.2.6, the extremely horrific and serious crime, which the public is concerned about, is only infrequently committed by insanity acquittees.

While most subjects in the Hans and Slater (1983) and Pasewark et al. (1981) surveys, correctly reported that insanity acquittees are often sent to hospital, there was underestimation

both of the length of time that most insanity acquittals spend hospitalised, and the level of security provided. Silver et al. (1994) reported that while the American public believes that 50.6% of insanity acquittees are sent to a mental hospital, the actual rate is 84.7%. Similarly, the public estimated the percentage of insanity acquittees that are set free to be 25.6%, and the actual rate is 15.3%. The public to be 21.8 months, when the actual length was 32.5 months, estimated the length of confinement of insanity acquittees. Public concern was also expressed about release procedures. Hans (1986) found that only a quarter of the respondents were confident that, those found not guilty by reason of insanity were released only after it was safe to do so, and 89% agreed with the statement 'the insanity defence allows too many people out on the street.'

More recently, McCutcheon and McCutcheon (1994) confirmed the continuing existence of these public myths with regards the insanity defence. They reported that most Americans believe that the insanity is a rich man's defence. Expert testimony was viewed as often conflictual, and it was believed that most insanity acquittees are freed shortly after trial. In this study, watching a television programme designed to expose these myths had little impact, however reading a brief factual report was successful in altering some misconceptions. Similar public perceptions were confirmed by Silver et al. (1994), who found that the most prevalent public concern expressed regarding the insanity defence, was that it is a loop hole through which many would be criminals escape punishment for illegal acts. Tygart (1992) sampled public opinion with regards the processes by which the public accepts mental illness and legal insanity, as a defence in homicide cases. Lesser acceptance was associated with political conservatism, traditional or orthodox religious beliefs, and a free will rather than a determinism philosophical stance.

Meta-myths

Perlin and Dorfman (1993) analysed the jurisprudential roots of the laws surrounding the insanity defence, and concluded that they have developed in an irrational and incoherent fashion, at least in part because of the persuasiveness of these myths. In his learned study of the development of legislation with regards the insanity defence, Perlin (1994) commented on the legal reform which took place in the United States, in the aftermath of the Hinckley trial (see

chapter 1.2 3). He argued that it reflected perfectly the contrast between insanity defence myth and reality. As he pointed out, the public call for reform following the unpopular insanity verdict, as in the previous sensational McNaughten case, was the result of tenuous logic, that is, the decision was wrong therefore the standard must be wrong. The use of other criminal law defences, even if a mistake is made, does not appear to evoke such a high degree of public emotion and involvement.

Perlin (1994) considered a number of background forces responsible for this situation. Public beliefs in this area involve what Perlin regarded as 'unconscious motivations', about such profound and fundamental issues as free will, responsibility, and blame. The symbolic value of the insanity defence therefore remains paramount. Perlin described the culture of punishment that flows from the medievalists' conceptions of sin, as having traditionally dominated beliefs in this area. Assumptions are made about who are the mentally ill, how they got to be that way, and what there is about them that allows us to treat them differently. There is also a widespread fear of mental illness, and the possibility that any individual, including ourselves, may become mentally ill. Also of relevance, is the ambivalence about psychiatry, held generally by the public and specifically by the legal system. Frequently there are doubts about mental health professional's ability to assess, and successfully treat mental illness. Social science data is disliked and distrusted by legal professionals, and psychological concepts are treated with suspicion.

Perlin (1994) discussed what he believes to be the meta-myths associated with the insanity defence, these are the social myths that have developed about and around the insanity defence, and result in the empirical myths as discussed above.

"When these (social meta-myths) are unpacked, there are at least four core governing principles that society is unwilling to abandon; the 'fear of faking' (that

mental illness is easily feigned for duplicitous purposes), the sense that mental illness is critically 'different' from other illnesses, the need for a successful insanity defendant to 'look crazy' (in a way that is consonant with popular mass media depictions), and ultimately, the idea that it is generally inappropriate to allow mental illness to excuse criminal punishment in all but the grossest cases."

(Perlin, 1994, p.10)

In analysing why these myths have continued, despite contrary scientific evidence, Perlin discussed two important processes. These are the use of heuristics in decision making, and legal reliance on 'ordinary common sense' (OCS). He discussed the impact of heuristic reasoning, whereby, implicit cognitive devices are employed to oversimplify complex information processing tasks, such as decisions about the legal status of mentally disordered offenders. Slovic and Tversky (1982) demonstrated that in order to keep the information processing demands of a task within the bounds of an individual's limited cognitive capacity, heuristics are utilised to simplify the process. However, the use of heuristics leads to distorted and erroneous decisions, and the ignoring or misuse of rationally useful information. Examples include, the availability heuristic, whereby there is a tendency to judge the frequency of an event, based on the ease with which one can recall occurrences of the event, and the simplifying heuristic, which involves the adoption of a stereotype, and the interpretation of subsequent information in keeping with the stereotype in the manner of a self fulfilling prophecy. Confirming information is remembered as relevant and reliable, and is accepted uncritically, whereas disconfirming evidence is not. Typically a small number of vivid, concrete cases, involving negative and extreme behaviour, and of dubious representative value, are recalled and generalised to the population of insanity acquittees.

Perlin (1991) also proposed the concept of OCS, which is nonreflective and self referential, as a powerful unconscious mediator of legal decision making in this area. Judges, whom he believes often express their perception of public feelings in the legal arena, frequently rely on OCS in their decision making. When defendants do not conform to lay conceptions of madness and craziness, the notion of mental illness significantly impacting on behaviour is rejected. As Perlin pointed out, this is an incomplete and imperfect tool with which to make

decisions in this area. Perlin and Dorfman (1993) questioned the role of social science data in this area. These authors noted the legal system's skepticism of social science data. The results of research from the disciplines of social science are seen as subjective and not as trustworthy, as the results from the pure sciences. Courts often use social science information in this area poorly, selectively, and inconsistently (Faigman, 1989). Perlin and Dorfman argued that the legal system either accepts or rejects the findings of social science depending on its needs. When the results of empirical research support the conclusions that the fact finder wished to reach, they are treated as privileged information, however it is rejected or ignored when it challenges pre-existing beliefs. This results in a 'pretextual' approach, that is, the implicit or explicit acceptance, of essentially 'dishonest' testimony. By the principal of cognitive dissonance, in order to avoid an inconsistent internal state, individuals tend to reject or reinterpret information that conflicts; either with internally held or publicly stated beliefs. Perlin and Dorfman describe the systematically selective use of information in this manner as 'sanist'.

"By this we mean that decision making in mental disability law cases, is inspired by (and reflects) the same kinds of irrational, unconscious, bias driven stereotypes and prejudices that are exhibited in racist, sexist, homophobic and religiously and ethnically bigoted decision making."

(Perlin & Dorfman, 1993, p.49)

The sanist manipulation and selective use of the findings of social science meets ends that are based on largely invisible, yet socially acceptable, irrational prejudice. Stereotype, myth and superstition, tend to be perpetuated by the use of OCS and heuristic reasoning. Many players in the legal area, including judges, lawyers, legislators, jurors and witnesses, hold sanist attitudes. Paradoxically, while a therapeutic orientation is used to provide justification for this decision making, Perlin and Dorfman (1993) proposed that the outcome for the individual often is not.

Perlin (1994) argued for the development of therapeutic jurisprudence, as articulated by Wexler and Winick (1992). Therapeutic jurisprudence examines the role that legal rules, procedures, and practices, have in producing therapeutic or antitherapeutic consequences, for individuals, society, and victims. It questions whether the law can be shaped to be more

therapeutic, while not subordinating it to traditional due process principals. Therapeutic jurisprudence requires the articulation and examination of values, and underlying agenda, which is relevant to the insanity myths. It also emphasises the importance of ongoing empirical evaluation.

The extent that this line of research generalises to the New Zealand context remains unknown. While it is questionable whether erroneous public perceptions are as intensely held in New Zealand, there does appear to be considerable fear and concern about mentally disordered offenders.

Summary

- (1) *There are a number of myths that surround the public perception of the insanity defence.*
- (2) *American research has demonstrated that these beliefs are, in fact, myths.*
- (3) *They can be traced to wider social meta-myths about the nature of madness and mental disorder.*
- (4) *Generalisation to the New Zealand context remains unknown.*

1.2.6 Empirical characteristics of those found not guilty by reason of insanity

Before reviewing the characteristics of those found not guilty by reason of insanity, it is important to note some important methodological issues that apply to empirical research conducted in this area. Many studies have been carried out in America, and jurisdictions other than New Zealand. The extent of generalisation is unclear, given both cultural and social differences, and differences in laws and legal standards. There is variability in the management of those in both the criminal justice and mental health systems, in different locations and countries. Attitudes toward the mentally ill and crime also vary and the availability of services, and community acceptance for using them, impacts on their use and success. Social conditions, such as the availability of firearms, are also relevant. Findings might, or might not apply, or apply in part, or in some circumstances, and replication is frequently necessary, in the unique New Zealand environment.

There are difficulties in operationalising mental disorder and criminality by reference to legal definitions. They often include assumptions that all mentally disordered people and offenders have been accurately identified. Lack of sufficient evidence to meet a legal criterion, does not necessarily mean that the actual mental disorder or criminal behaviour does not exist.

In the studies discussed below, the samples are often mixed in that many include both insanity acquittees and those found unfit to plead (Daniel, Beck, Harath, Schmitz, & Menninger, 1984; Warren, Fitch, Dietz, & Rosenfeld 1991; Warren, Rosenfeld, & Fitch, 1994; Mackay & Ward, 1994). The study by Steadman, Rosenstein, MacAskill, and Manderscheid (1988) described the features of mentally disordered offenders treated in inpatient units generally. There are also variations, amongst the studies, in the comparison groups that were used. The studies by Callahan et al. (1991), Pasewark et al. (1987), and Steadman, Keitner, Braff, and Arvanites (1983), compared insanity acquittees with those who unsuccessfully raised an insanity defence. Daniel et al. (1984) compared their sample of insanity acquittees and those found to be incompetent to stand trial, with those that were psychiatrically evaluated, and found to have no psychiatric defence.

The studies by Boehnert (1987; 1988) compared four groups. Those found not guilty by reason of insanity were compared with other defendants who had been psychiatrically evaluated, a group matched on the index crime for whom there was no psychiatric involvement, and a group of psychiatric controls. In their Canadian studies, Rice and Harris (1990) and Harris, Rice, and Cormier (1991) have also studied random groups of defendants who had been psychiatrically evaluated, and other groups who had been evaluated and who were matched on the index offence. Other studies have compared results with those found with incarcerated offenders generally (Steadman et al., 1988). Some studies are descriptive only, and do not include a comparison group (Bloom, Williams, & Bigelow, 1992; Bogenberger, Pasewark, Gudeman, & Beiber, 1987).

Demographic information

While the jurisprudential history of the insanity plea is centuries old and the legal standards for insanity have essentially remained unchanged for over a century, empirical research has developed only over recent decades. Steadman (1985) reviewed the earlier descriptive studies of insanity acquittees, and noted the consistency of the findings both across time and jurisdiction. He concluded that in terms of demographic characteristics, insanity acquittees tended to be in their late twenties to mid thirties, male, disproportionately white as compared to state prison populations, of moderate education, and frequently unskilled, or unemployed. The Steadman (1985) review, found wide variation with regards the issue of the seriousness of the crimes of insanity acquittees, however, minor property crimes were frequently described.

Samples of insanity acquittees, consistently find that the majority are male. Steadman et al., (1983) reported that 88% of their sample were male, Callahan et al. (1991) found that 90% were male, and Hodgins (1983) reported that 87% were male. In the study reported by Zonana, Bartel, Wells, Buchanan, and Getz (1990), 10% of their total sample of insanity acquittees, were females. This compared with rates of about two to five percent in the prison population. While Steadman (1985) concluded that the reasons for there being a greater proportion of females, amongst samples of insanity acquittees than in the prison population were unclear, Zonana et al. proposed that they are likely to be based on chivalrous notions about the reasons for women committing crime., Etiologies based on notions of insanity, are somehow more palatable for females, within the criminal justice system. This study made comparisons between a group of female insanity acquittees, who were matched with male insanity acquittees, and found that women were older (the mean age for males was 28.5 years and for females 36.4 years), more likely to be married, less likely to be substance abusers, had less extensive criminal histories, and were released from hospital sooner than the men. These results are consistent with earlier studies, which have also reported that female insanity acquittees have fewer arrests both before and after insanity acquittal (Pasewark, Pantle, & Steadman, 1979; Steadman, 1980), are acquitted on different types of crime from men, more frequently involving murder or attempted murder (Pasewark et al., 1979; Rogers, Sack, Bloom, & Manson, 1983; Steadman, 1980), and are

hospitalised for shorter periods of time (Rogers et al., 1983). Most studies of insanity acquittees, make only limited comparisons of males and females. This is likely because the total number of women is small.

Studies have generally found no association between the race of the defendant and an adjudication of insanity (Braff, Arvanites, & Steadman, 1983; Callahan et al., 1991; Daniel et al., 1984; Pasewark et al., 1987). Bogenberger et al. (1987) found that the ethnic distribution of their sample of insanity acquittees reflected that of Hawaii, where this study was conducted. Zonana et al. (1990) in their comparison of male and female insanity acquittees, however, found a significant racial difference in that white women had less extensive forensic histories, and shorter periods of hospital admission than did women from minority races.

Most studies find that insanity acquittees tend to be older than other criminal defendants and the general prison population, and are most frequently in their late twenties or early thirties (Jeffrey, Pasewark, & Bieber, 1988; Pasewark et al., 1987; Rice & Harris, 1990; Steadman, Keitner et al., 1983). Boehnert (1987) found no age difference in the comparisons that were made with matched control groups.

Marital status does not appear to be significantly different between insanity acquittees and comparison groups (Daniel et al., 1984; Pasewark et al., 1987). However, most insanity acquittees are unmarried. Steadman, Kietner et al. (1983) reported that 88% of their sample were single, which is only slightly higher than the 66% found by Jeffrey et al. (1988), and the 61% by Bogenberger et al. (1987). Rice and Harris (1990) found that only 42% of their sample of insanity acquittees had ever been married. As suggested above, the finding with regards marital status may not hold true for female insanity acquittees.

There are also no major differences on the variables of employment status or history, when insanity acquittees are compared to other groups, however, there are high rates of unemployment overall (Boehnert, 1988; Daniel et al., 1984; Pasewark et al., 1987). Rice and Harris (1990) however, found that fewer insanity acquittees were employed. Steadman, Kietner et al. (1983) reported that 72% of their sample of insanity acquittees were unemployed or

unskilled, and Jeffrey, Pasewark, and Bieber (1988) found that 74% were unemployed at the time of arrest. This is similar to the 71% reported by Bogenberger et al (1987) to be unemployed at the time of the index offence. Pasewark et al. (1987) characterised 93% of their sample as chronically unemployed. Rice, Harris, Lang, and Bell (1990) reported no difference in family socio-economic status when insanity acquittees were compared to convicted offenders.

Most studies have found that insanity acquittees have lower levels of educational attainment than those in prison, or samples of defendants who had been psychiatrically evaluated but sanctioned within the criminal justice system (Rogers, Seman, & Stampley, 1984; Rice & Harris, 1990), or those who unsuccessfully raise the insanity defence (Bogenberger et al, 1987). Boehnert (1987) found no difference in the educational levels of insanity acquittees, those evaluated for the insanity defence, and imprisoned offenders. Psychiatric controls in this study, were better educated. In contrast Rogers, Seman, and Stampley (1984) found that insanity acquittees were relatively well educated, and Pasewark et al. (1987) reported that those with higher levels of education were more likely to be found not guilty by reason of insanity.

Summary

- (1) *Defendants who are found not guilty by reason of insanity are mostly male, however females are over represented, compared with the prison population.*
- (2) *There does not appear to be any association between the ethnicity of the defendant, and findings of not guilty by reason of insanity.*
- (3) *Defendants who are found not guilty by reason of insanity tend to be older than other criminal defendants.*
- (4) *They are most often not married, unemployed, and of low socio-economic status.*
- (5) *Mixed findings have been found when educational levels are considered.*

Crime information

While there are variations in absolute rates across studies, it is clear that most insanity acquittees have had previous contact with the criminal justice system, as measured by either prior arrest or conviction rate. Jeffrey, Pasewark, and Bieber (1988) found that 73% of their sample, had been previously arrested at least once, which is the same percentage reported by Pasewark et al. (1987). Hodgins (1983) reported a lower previous arrest rate of 39%, and Bogenberger et al. (1987) found 57%. Bloom et al. (1992) in describing their sample of insanity acquittees who had been diagnosed with schizophrenia, reported that defendants had an average of 5.9 prior criminal justice contacts, and that the mean number per year as an adult was 0.57. Therefore their prior contact with the criminal justice system had been considerable.

Studies have found no differences in the number of prior arrests, when insanity acquittees are compared with the prison population (Boehnert, 1987; Daniel et al., 1984; Pasewark et al. 1987), but more extensive criminal histories when compared with psychiatric controls (Boehnert, 1987; Callahan et al., 1991). It is likely however, that when crime especially if it is not of a serious nature, is detected amongst psychiatric patients they may be directed to the mental health system, and also that psychiatric patients are more closely followed up and monitored in the community. Some support for this hypothesis, comes from the study by Boehnert (1987), which did not find any difference between insanity acquittees and psychiatric controls, in their histories of violence, rather than criminal convictions.

When the nature of the criminal offending prior to the index charge is studied, considerable numbers of insanity acquittees have histories of committing nonserious or minor crime. Pasewark et al. (1987) reviewed all the previous crimes committed by insanity acquittees, and found that 18.8% were against the person, 51.3% were against property, 12.4% were drug offences, and 14.1% were against public standards. The remainder related to minor crime. There was no difference in the number of previous felony charges, between those who were successful, and those who were unsuccessful, in raising the insanity plea. Golding, Eaves, and Kowaz (1989) also reported that most of the previous crimes of their sample of insanity acquittees, were minor

assaults, property and theft crimes, and nuisance crimes. There was no relationship between prior type and number of charges, and the index offence. Bloom et al. (1992) reported that 55% of all the prior convictions of insanity acquittees were for felonies, and Bogenberger et al. (1987) found that 37% of their sample of insanity acquittees, had previously been convicted of a felony offence. In detailing the type of crime committed prior to the index offence, 42% had been convicted of crimes against property, 23% against public order, 17% against persons, and 12% drug offences.

There is some debate about the seriousness of the index offence with which insanity acquittees are charged. Golding et al. (1989) reported that 30% of their sample of insanity acquittees, had faced charges related to minor, non-violent, nuisance crime. Callahan et al. 1991 found that 50% faced charges relating to robbery, property, and minor crimes, and concluded that serious crime was more frequent amongst those who unsuccessfully raised the insanity defence. In the sample studied by Bogenberger et al. (1987), 50% faced robbery or other property charges. Daniel et al. (1984) found no relationship between the seriousness of the index crime, and findings with regards competency, or responsibility. In their Canadian sample, however, Rice and Harris (1990) reported that 40% of insanity acquittees faced charges of murder. Ogloff, Schweighofer, Turnbull, and Whitmore (1992) have pointed out that while statistics on the index crimes of those found not guilty by reason of insanity reflect original charges, it is likely that these would have been reduced by plea bargaining had the issue of insanity not been at stake. Quinsey (1981) proposed that although seriousness is not part of the definition of insanity, it is relevant in that few of those involved in the legal process would see value in subjecting those facing minor charges to indeterminate hospitalisation, which may be a consequence of a not guilty by reason of insanity adjudication. Support for this interpretation, comes from the study by Packer (1987) in Michigan, which found that following a court decision which ended mandatory hospitalisation for insanity acquittees, the number of verdicts of not guilty by reason of insanity increased for those facing minor charges.

Summary

(1) *Most insanity acquittees have previous convictions.*

- (2) *These appear to be most often for less serious types of crime.*
- (3) *There is debate as to the seriousness of the index charges.*

Clinical information

Most studies of not guilty by reason of insanity cohorts find high rates of prior hospitalisation, and mental health contact, with these rates being higher than comparison groups. Typically two thirds or more, are likely to have a history of psychiatric treatment (Callahan, Steadman, McGreevy, & Robins, 1991; Golding et al., 1989; Hodgins, 1983; Jeffrey et al., 1988; Pasewark et al., 1987; Stokman & Heiber, 1984). Pasewark et al. (1987) found that 80% had experienced either outpatient or inpatient treatment and that this variable was significantly associated with adjudication. Bloom et al (1992) in their study of insanity acquittees with schizophrenia, reported that in the two year period prior to the alleged index offence, 81% had received services from the mental health system, and that subjects had spent an average of 13% of that time in hospital. Rice and Harris (1990) explained their finding of insanity acquittees having less extensive psychiatric history, in terms of their control group of those who were psychiatrically evaluated, but did not have an insanity defence. They proposed that in Canada, defendants might be remanded for evaluation, on the basis of a psychiatric history. Callahan et al. (1991) in another Canadian study, also emphasised the high rates of prior hospitalisation amongst those who unsuccessfully raised the insanity defence. Boehnert (1987) found no difference in the rate of prior hospitalisation, when a sample of insanity acquittees was compared with psychiatric controls.

Despite this fairly robust finding of high rates of previous psychiatric hospitalisation, few studies have reported on the reasons for prior hospitalisations, for example, whether it was voluntary or involuntary, other mental health contacts, and their chronological relationship to the current presentation. It is unknown whether prior hospitalisations were for the same, a distinctly different, or a related disorder. It would be valuable also to know about the types of treatments

that were employed, and their outcome. Phillips and Pasewark (1980) reported that about 60% of their sample had prior hospitalisations, and 60% of these were related to criminal proceedings.

When considering the current mental disorder, there are differences in whether symptomology or diagnoses are investigated. Nevertheless, there are consistent findings that insanity acquittees are more likely to have a diagnosis of schizophrenia, or psychosis, typically at rates of about 80% (Boehnert, 1988; Bogenberger et al., 1987; Daniel et al., 1984; Pasewark et al., 1987; Rice & Harris, 1990; Rogers, Bloom, & Mason, 1984; Rogers, Seman, and Stampely, 1984; Steadman, Keitner et al., 1983; Steadman et al., 1988). Schizophrenia was more frequent amongst those that were found to be not guilty by reason of insanity than in those that unsuccessfully raised the defence (Callahan et al., 1991; Pasewark et al., 1987). Callahan et al. noted, however, that the majority of those that attempted to use the defence were mentally ill, and 90% had received a DSM-III diagnosis. Rice et al.(1991) reported, that 13% of their matched comparison group of convicted offenders, met the DSM-IIIR criteria for psychosis.

Affective disorders such as depression are usually diagnosed more frequently in control groups, than in samples of insanity acquittees (Boehnert, 1987). An exception to this appears to be bipolar affective disorder. This is probably because psychosis more often occurs with this disorder. London and Taylor (1982) found that 34% of their sample of insanity acquittees, had been diagnosed with bipolar affective disorder. However much lower rates were reported by Wulach (1983) who reviewed over five thousand discharges from a New York hospital forensic unit, and found that only 2% had this diagnosis. Pasewark et al. (1987) reported that 4% of their sample of insanity acquittees had been diagnosed with bipolar affective disorder.

Both Boehnert (1988) and Rice and Harris (1990) reported that 13% of their samples of insanity acquittees had diagnoses of personality disorder, however, the diagnosis was less likely than in comparison groups. Pasewark et al. (1987) also found that personality disorders occurred more frequently amongst those who unsuccessfully raised the insanity defence, than amongst those that were successful. Daniel et al. (1984) also concluded that this diagnosis was more

frequent amongst those who had been psychiatrically evaluated and did not raise either the issue of insanity or incompetence.

Jeffrey et al. (1988) and Pasewark et al. (1987) found that insanity acquittees were significantly less likely to have a history of drug abuse, than other defendants and Rice and Harris (1990) reported that insanity acquittees, were less likely to be drunk at the time of the index offence, than convicted offenders. However, overall rates of alcohol and or drug related difficulties appear high. Pasewark et al. (1987) found that 68% of insanity acquittees had a history of alcohol and or drug abuse.

Boehnert (1987) studied a group of defendants who unsuccessfully raised the insanity defence and were found guilty, and sent to prison. While the sample size was small, he developed an interesting typology that warrants replication. Using detailed file data, historical information, and psychometric test results, he identified five groups. The first group was those who were chronically psychotic, yet too dangerous to send to a psychiatric hospital, and were mandated to have psychiatric care in prison. The second group was socially isolated, or inadequate individuals who had raped, murdered or molested. Offenders in the third group, were those who had injured or killed law enforcement officials, and tended to be personality disordered and to have long criminal histories. The fourth group, were those who had relatively little previous contact with social services, and their criminal offending was related to their familial situation, or intimate relationships. The fifth and largest group, was made up of those who had committed violent and often bizarre offences, usually against strangers. Personality disorder was frequent amongst this group, as was substance abuse. Overall, those who unsuccessfully raised the insanity defence, were characterised as having had committed more heinous crimes, and having relatively good intelligence, poor impulse control, and a tendency toward aggression. These features are typical of people described by Hare and Hart (1997) as psychopathic. The hypothesis that psychopaths and those with other personality disorders, may feature predominantly amongst those who are psychiatrically evaluated but for whom the insanity defence is not raised, is supported by the findings of Daniel et al. (1984), who reported that those with primary diagnosis of substance

abuse, or personality disorder, were more likely to be amongst those evaluated but returned to the court for criminal processing.

Summary

- (1) *There are high rates of prior hospitalisation amongst samples of insanity acquittees.*
- (2) *Most have a diagnosis of schizophrenia, or bipolar affective disorder, with psychotic features.*

Prediction of insanity acquittal

Some research projects have looked at the comparative weight of variables, and how defendant and offence characteristics, relate to ultimate case disposition. Steadman, Keitner et al. (1983), using univariate statistics, found that defendants in the age group 25-39 years, those with five or more psychiatric hospitalisations, and those considered insane following psychiatric assessment, were more likely to be found not guilty by reason of insanity. Rogers, Seman, and Stampley (1984) also using univariate statistics, reported that an insanity adjudication was related to prior history of schizophrenia, completion of high school, and a psychiatric finding of insanity, at the time of the crime.

Daniel et al. (1984) employed a series of discriminant function analyses, and found that the factors most influential in determining recommendations to the court of insanity, amongst those who had been psychiatrically evaluated, were mental status at the time of the offence, psychotic symptomology, and DSM-III diagnosis. Jeffrey et al. (1988) using 35 variables and discriminant function analyses, of male defendants entering the insanity plea in Colorado, correctly classified 87% into those convicted or found not guilty by reason of insanity. Most positively related to insanity findings were psychiatric evaluations of insanity, and diagnoses of schizophrenia. Negatively related were diagnoses of substance abuse, and personality disorder.

Rice and Harris (1990) also using multiple discriminant analyses, found that the most important determinants of a finding of not guilty by reason of insanity, were index offence (violent crime was associated with insanity), and psychiatric diagnosis. These authors concluded that,

most decision making in this area could be modelled, by saying that insanity acquittees are those who are accused of murder or attempted murder, who show evidence of psychosis during psychiatric examination. Rice and Harris (1990) argued that the variance that remained, could be attributed to factors such as the number of forensic psychiatrists in the community, and the personal interest of judges.

1.2.7 Reliability and validity

Most defendants who are insane are reliably diagnosed as psychotic, by multiple examiners (Roger, Boom, & Manson, 1984). However these results need to be interpreted with reference to the high base rate of those found not to be insane. In the study by Daniel et al. (1984), 80% of insanity cases were uncontested, and those cases which involved a diagnosis of personality disorder accounted for the highest number of disagreements amongst professionals. Sadoff (1992) commented that in contrast to prevailing myth, psychiatrists most often agree on the presence of mental illness, and what is more often debated is the application of the mental illness, to the insanity test used in that jurisdiction.

It is difficult to establish the validity of decisions with regards to insanity. This is because, there is no external criteria with which to compare these judgements. Nevertheless, it is clear that diagnoses of psychoses are highly associated with expert opinions of insanity (Rogers, Cavanaugh, Seman, & Harris 1984; Finkel & Duff, 1989). It is also evident that expert opinions in these matters are highly associated with actual adjudications. For example, Steadman, Keitner et al. (1983) reported a 70% concordance rate between those evaluated insane by psychiatric examiners and court adjudications of insanity, and Jeffrey et al. (1988) found 88% agreement. Steadman, Keitner et al. (1983) and Rogers, Bloom, and Manson (1984) attributed the high concordance rate between psychiatric recommendation and outcome to the potency of psychiatric evaluation. Fukunaga, Pasewark, Hawkins and Gudeman (1981) however, put forward an alternative hypothesis, that two independent bodies evaluating the same circumstances reached the same conclusion.

A study by Homant and Kennedy (1987) found that juries followed the recommendations of expert witnesses about 90% of the time. Tygart (1992) asked mock jurors, about the weighting given in decision making to psychiatric testimony. A minority of 37% would grant the testimony of a psychiatrist 30% or more of the weight in their decision making. Those who were more influenced by the testimony of experts were more favourable toward a defence based on mental disorder. Subjects who were proponents of the insanity defence, were more influenced by the testimony of experts, if it supported their original position. Those who were opposed to the insanity defence remained opposed, even if an expert concluded that there was clear evidence of an insanity defence. While juries agree with experts, it is clear from the work discussed above (chapter 1.2.5) that lay people rather than relying on expert opinion, tend to rely on internal, social and moral constructions of insanity.

Summary

- (1) *There is a high degree of concordance between the opinions of mental health professionals and the outcome of the case. This does not necessarily imply that their decisions are valid.*
- (2) *Diagnoses of psychoses amongst criminal defendants are reasonably reliable.*

1.2.8 Clinical assessment

The process

Ogloff et al. (1993) discussed some of the unique aspects of forensic clinical investigation and evaluation, and the ways in which this differs from other the other clinical work of mental health professionals. By definition, evaluation of nonresponsibility requires evaluation of the defendant's mental state at the time of the offence. Assessment, therefore, is retrospective, and Ogloff et al. questioned whether it is ever possible to gain access to perfectly valid information, both prior to, and during the alleged criminal act. Even if this ideal was met, the task still requires interpretation, or construction of the meaning of the defendant's behaviour, which is

difficult because of the time delay, and inevitably requires some degree of speculation. Ogloff et al. regarded the clinical investigation as:

“fundamentally an investigative endeavour that attempts to retrospectively reconstruct the cognitive, conative, emotional, motivational and psychopathological concomitants, and determinants of the defendant's behaviour at the time of the crime.”

(Ogloff et al, 1993, p.169)

These authors also provided a valuable outline, of five phases involved in the clinical assessment of insanity. The first of these is the establishment of the clinical, evaluative relationship. Psychiatric assessments are court ordered, which brings up the question as to who is the client. In most clinical situations, the person goes to the mental health professional seeking relief from emotional pain or problematic behaviour, but in clinical assessments of insanity these are ordered often involuntarily, by a third party, the court. In most clinical assessments, there is an expectation that the client will be honest, however, this cannot be assumed in forensic assessments. There are also limits on confidentiality, and any information gathered can be used in a distinctly different manner, than in general clinical assessments. These features need to be outlined to the person undergoing assessment.

The second stage is the gathering of a psychosocial history. Multiple sources of information are collected, if available, including educational, mental health, and prison records, and examination is made of the development of past patterns of dysfunctional behaviour. Any past episodes of mental illness are reviewed, and response to intervention considered. History of drug and alcohol use is evaluated, as is any history of head injury, organic impairment, or intellectual difficulties that may be relevant.

The third stage in the process is an evaluation of present mental state and usually the assignment of a diagnosis. It is noteworthy, however, that the presence of current mental disorder bears only a probabilistic relationship to prior mental disorder, at the time of the crime. There is no necessary relationship between a person's mental status at these two distinct points in

time, and there is also no definite relationship between clinical diagnosis, and the legal criteria of insanity.

Inquiring about mental state at the time of the offence is the next clinical task. During this stage, particular inquiry is made into the impact of any mental disorder, and the ways in which symptomology may have influenced psychological processes. Golding and Roesch (1988) have referred to this as the 'psychological autopsy'. It involves a reconstruction of events and the defendant's mental status at the time of the crime. Reference may be made to the police report of events. Alternative explanations require exploration and challenging, and the possibility of malingering must be considered, while continuing to maintain rapport. The use of standardised scales is sometimes included in the assessment and these are discussed below.

In the final stage of the assessment process, reconciling possibly conflictual data is involved, and the formulation of an opinion for the court is made. An explanation is given, in language that is understandable to the court, as to how cognition and behaviour, may have been influenced by mental disorder. The probabilistic nature of the assessment is relevant, as is any possible source of error, including undetected malingering and examiner bias. An ethical and professional issue is how closely to relate clinical findings to the legal concepts inherent in the prevailing insanity standards. The difficulty is that to do so would be to comment, also, on the ultimate issue of insanity. This is problematic, in that in describing how psychopathological processes relate to psycholegal concepts, for example, how delusions might influence a person's knowledge of events, some commentary on the ultimate issue is inevitable, unless there is to be a loss of relevant information. Ogloff et al. (1993) concluded by questioning whether psychologists and psychiatrists should be involved at all in the legal determination of insanity.

Standardised assessment measures

The Rogers Criminal Responsibility Assessment Scale (R-CARS) (Rogers & Cavanaugh, 1981), was developed as a standardised measure of criminal responsibility, that aimed to provide reliable and relevant information to the courts. It was designed to translate the ALI concept of legal insanity, into 25 quantifiable variables, which were grouped into five areas of psycholegal

relevance. These are the reliability of the report, organicity, psychopathology, cognitive control, and behavioural control. Ordinal ratings are made by clinicians, following a diagnostic structured interview, and observations.

The nature of the R-CARS as a standardised test or a structured guide, has been debated in the literature, with the core issues, centering around its psychometric properties, particularly given its goal of relating clinical characteristics to legally relevant standards (Goldstein, 1987). Rogers and Ewing (1992) have argued that it is a standardised assessment method for which reliability, validity, and generalisability can be demonstrated. These authors cautioned, however, about the potential risks of putting too much weight on a numerical cut-off score.

Moderate interrater reliabilities for the five area scores and final score have been demonstrated (Rogers, Dolmetsch, Wasyliv, & Cavanaugh, 1982), and a high correspondence shown between clinical opinion as determined by the R-CARS and final legal adjudications (Rogers, Cavanaugh, Seman, & Harris 1984). Validity has been difficult to establish, at least in part, because it necessarily reflects psycholegal criteria, which themselves are based on social constructions, and are therefore difficult to consistently and accurately measure. However, there is some evidence of construct validity based on a priori hypotheses testing (Rogers, Seman, & Clark 1986), and the factorial structure of the measure is consistent with the theoretical components of the legal insanity standard (Rogers & Ewing, 1992). Rogers and Cavanaugh (1981) provided some evidence of generalisability, with respect to demographic variables (gender, race and age), legal variables (fitness to plead and prior arrest history) and the profession of the examiner (psychologist or psychiatrist). The extent of generalisation to other settings and jurisdictions, such as New Zealand, which employ legal standards other than the ALI, remains untested.

Rogers and Ewing (1992) argued for the increased use of the R-CARS in conducting insanity assessments, by pointing out difficulties with its main alternative, which is clinical evaluation. There is little doubt, that there is marked variability in traditional clinical evaluations

with regards content, method and decision making. Reliability and validity, remain both unknown, and untested.

While the debate about the role of expert testimony and their commentary on the ultimate issue, is ongoing and complex the R-CARS does offer the alternative of not providing a final opinion. Criticisms have also been made with regards the extent of its 'general acceptance', within the scientific community. There are limitations in the use of the R-CARS and it does not simplify complex assessments, it does however provide for comprehensive and systematic data collection, explicit decision models, and some standardisation of the assessment process, in those jurisdictions that utilise the ALI standard.

An alternative measure is the Mental State at the time of the Offence Screening Evaluation (MSO) (Slobogin, Melton, & Showalter, 1984), that was designed as a screening measure for a range of legal defences including insanity. It consists of three parts, including history of mental disorder, impairment at the time of the offence, and a current mental status examination. While some initial information with regards validity was provided by the authors, reliability and generalisability, is unknown and it does not appear to be widely used.

Summary

- (1) *The clinical assessment of insanity, involves some unique tasks that are fundamentally different from those usually conducted by mental health professionals.*
- (2) *American researchers have developed a number of structured screening, and assessment inventories, that assist the decision making of clinicians. They are however, not used in New Zealand because they do not relate to the relevant legal standard.*

1.2.9 Confinement patterns

Little is known about the treatment of those found not guilty by reason of insanity, and subsequently hospitalised. Heilbrun, Nunez, Deitchman, Gustafson, and Krull (1992) conducted a nation-wide survey of American public hospitals, treating insanity acquittals, those found incompetent to stand trial, and mentally disordered inmates. Psychotropic medication was most frequently used in treating mental and emotional disorders, violence and self-injury, while sexual deviancy and substance abuse, were usually treated by individual counselling. The components of this counselling were not specified. Behavioural and cognitive-behavioural methods of treatment were reported infrequently however, even in areas that the authors regarded that they would be useful, such as violence and sexual deviancy. Again, the extent to which studies such as these generalise to New Zealand, and reflect current practices is unclear.

It appears that psychotropic medication constitutes the main treatment modality in many psychiatric institutions, and most medications target psychotic processes generally, rather than focusing on the specific symptoms that were regarded as having caused the alleged offending. Increasingly, cognitive methods for dealing with unrealistic thoughts and beliefs, are being used as a valuable treatment adjuncts (Fowler, Garety, & Kuipers, 1995), and these methods would appear to have more ability to address the specific psychotic symptoms, that led to the person coming into contact with the criminal justice system.

A series of empirical research studies have focused on the length of confinement of insanity acquittees. While research has found that insanity acquittees are confined for longer periods of time, than those convicted for similar offences (Harris, Rice, & Cormier, 1991; Pogrebin, Regoli, & Perry, 1986), other studies have found no difference (Braff et al., 1983; Kahn & Raifman, 1981), or shorter periods of confinement (Pasewark, Pantle & Steadman, 1982; Phillips & Pasewark, 1980). These differences are likely to be because of the use of small sample sizes and variation in the management of insanity acquittees across jurisdictions. Silver (1995) reported that there is considerable variability, amongst the States in America, in how insanity

acquittees are managed, compared with those who are convicted. Across seven States, there were mixed results as to whether insanity acquittees, would have spent more time in custody if they had been convicted. Golding et al. (1989) reported that the average insanity acquittee in British Columbia spent nine and a half years in confinement, or under supervision, after being found not guilty by reason of insanity. These authors provided evidence that most improvement, across a variety of measures, occurred during the initial period of confinement during which patients were stabilised on medication. With reference to the 30% of their sample, who faced minor non-violent crime, they commented that concern about public safety was not relevant in these cases, and they regarded these detention periods as contrary to humane or pragmatic considerations. MacKay and Ward (1994) looked at the issue of the long term detention of patients found not guilty by reason of insanity or unfit to plead. They reviewed cases of those who had been detained for fifteen years or more in special hospitals in England. The three reasons that were apparent for continued confinement were that the patients remained mentally ill and in need of treatment, perceptions of dangerousness, and the apparent desire of the patient to remain where they were. Pasewark (1986) also reported that these patients were typically confined until they are no longer a danger to themselves. Theoretically, insanity acquittees are sick and in need of treatment until they recover from the symptoms that led to the original crime, however, in practice most are involuntarily maintained for long periods of time in secure hospitals.

The length of the confinement of those found not guilty by reason of insanity, has been consistently related to the seriousness of the initial crime, for which the person faced charges (Steadman, Pasewark, Hawkins, Kiser, & Bieber, 1983; Harris, Rice, & Cormier, 1991; Braff et al., 1983; Baldwin, Menditto, Beck, & Smith, 1992). This finding holds across different jurisdictions, and with varying definitions of length of detention (Silver, 1995). It is a robust finding that offence seriousness is more important than mental disorder in determining the period of confinement of insanity acquittees.

Roberts and Golding (1991) and Steadman (1985) questioned the basis of the association between the seriousness of the original crime and the length of confinement that occurs,

particularly in cases of serious crime. There is no empirical support for the hypothesis, that more serious crime is associated with greater degrees of mental disorder, or a necessity for longer periods of treatment. Quinsey and Maguire (1986) reported that the seriousness of the original crime is used by clinicians as a primary indicator of dangerousness, and Ogloff et al. (1992) argued that release decisions are often based on judgements with regards dangerousness.

Silver (1995) challenged the theoretical implications of these findings. He questioned whether the confinement patterns of insanity acquittees, reflected an underlying punishment model, whereby insanity acquittees are punished, according to the seriousness of the crime for which they were found not guilty, despite the underlying tenant of the insanity defence, that punishment is not justified for insanity acquittees who are not responsible for their behaviour. Mental health treatment therefore, becomes the mode of social confinement. Silver (1995) argued that to the extent that assessments of dangerousness, associated with decisions about releasing insanity acquittees reflected the seriousness of the offence for which the insanity defendant was acquitted, they function as a mechanism for sentencing and punishment. The association between length of confinement, and offence seriousness rather than degree of mental disorder, or treatability is referred to by Morris (1982) as:

“a tribute to our capacity to pretend to a moral position while pursuing profoundly different practices.”

(Morris, 1982, p.59)

The report of Quinsey and Maguire (1979) that mentally retarded patients stayed longer in hospital than other patients, at least in part because they were unlikely to obtain legal representation for review board hearings, and the finding of Rice et al. (1991) that IQ and assertion were related to length of hospitalisation, both suggest that one possible factor is the ability of the insanity acquittee to make his or her case to the appropriate authorities. Whereas those who are convicted in a criminal court, have a determinate sentence length, this is not so for insanity acquittees.

Rice et al. (1991) hypothesised that decisions about release are largely political. If there has been a recent salient example of horrendous offending by a mentally disordered offender, release decisions will become more conservative. Human decision making is often influenced by a number of intuitive processes, and is subject to a number of biases and errors, that likely apply in this area.

In an interesting study, Elliott, Nelson, Fitch, Scott, Wolber, and Singh (1993) questioned the extent to which defendants were informed about the consequences of the insanity defence, in the light of findings that those facing minor charges are often detained for longer periods, than if they had been criminally convicted. By retrospective review and concurrent evaluations, using a structured questionnaire, these authors determined that in Virginia, either attorneys or judges did most frequently not consider this. They argued both that legal personnel be further educated in providing this information, and that laws be changed, to recognise the importance of these elements in the decision making process with regards the insanity plea.

This conflict of purpose is also reflected in public opinion surveys. It appears that there is strong public support for both punishing insanity acquittees, and for providing mental health treatment. The Hans (1986) public telephone survey found that 55% of respondents agreed that 'the insane should be punished like everyone else, when they break the law', 36% regarded that it was wrong to punish insanity acquittees, and 96% agreed that insanity acquittees should be provided with mental health treatment. The release decisions made in psychiatric hospitals, for insanity acquittees, likely reflects a reaction to public concerns.

Summary

- (1) *Insanity acquittees often face indeterminate confinement.*
- (2) *It is a fairly robust research finding that the length of confinement of insanity acquittee is more closely associated with the seriousness of the original charge, than with improvement in mental state. It has not however, been tested in New Zealand.*
- (3) *This is theoretically problematic, given the therapeutic rather than punitive basis of the insanity defence.*

1.2.10 Social adjustment following discharge

It is difficult to both define and measure the social adjustment and success of insanity acquittees, when they are discharged from hospital. However, most research has emphasised the problems that are experienced. Quinsey, Cyr, and Lavelle (1988) attempted to identify the community adjustment difficulties that are experienced by forensic patients on discharge. They devised seven scales (psychotic, affective, criminal identification, institutional aggression, life skills, social skills and institutional adjustment), that in addition, to substance abuse and anger control, were related to individual progress. Heilbrun, Lawson, Spier, and Libby (1994) usefully explored the 'fit', between the insanity acquittee's individual characteristics and the community placement. Success is likely to be, at least in part, dependent on the interaction between these variables.

Research that examines recidivism and subsequent presentations, varies in the length of follow up, and the manner in which the criterion variables are operationalised. Studies of the success and recidivism rates, of those that enter the mental health system are complicated, in that treatment relevant variables are often not included (Steadman, Pasewark et al., 1983). Only those judged not dangerous are released into the community, so there is never any true validation of predictions of dangerousness. Many of the behaviours of concern such as violence occur at low base rates, or are quite situationally specific, so large samples are necessary. A further complicating methodological problem in this area of research is that it is also possible, those if criminal behaviour occurs while an insanity acquittee is in the community that they are hospitalised or reassessed, and are not charged within the criminal justice system.

Ogloff et al. (1992) in reviewing the studies of the recidivism rates of insanity acquittees, reported that rearrest rates are variable, and range from the 9.6%, found by Rogers and Bloom (1982) in Oregon, to the 65% reported by Phillips and Pasewark (1980) in Connecticut. Differences in community follow-up and monitoring, are likely to account for some of this variation between these studies. Bogenberger et al. (1987) argued that the relatively low recidivism rates of insanity acquittees found in Canada and in Oregon, is related to the high level

of community follow up in these jurisdictions. These authors found that 67% of insanity acquittees discharged from hospital, were arrested over a five year period, and that 56% had been arrested on felony charges. However, most of these later cases were of a less serious nature than the index charges. Bloom et al. (1992) described a conditional release programme, which involved intensive community monitoring, and reported that under this system, insanity acquittees with schizophrenia had an average of 0.4 criminal justice contacts per year, following discharge which was significantly lower than before admission. Of these contacts, 57% were for misdemeanour offences. It appears that once insanity acquittees are released into the community, they are at considerable risk of offending. While there are some inconsistent findings, generally reoffence rates are not significantly different from comparison groups of convicted offenders, or are lower (Belfrage, 1991; Phillips & Pasewark, 1980; Pasewark et al., 1982; Silver, Cohen, & Spodak, 1989). Ogloff et al. (1992) reported that when an insanity acquittee reoffends it is frequently for minor or drug charges, however, it is possible that those with violent tendencies were not released from hospital. In contrast, Tellefsen, Cohen, Silver, and Dougherty (1992) reported that following discharge, insanity acquittees were more likely to be arrested than defendants who were convicted, and this was particularly so for serious crimes.

Other studies of insanity acquittees, also support the conclusions that age and offence history, are most closely related to recidivism (Bowden, 1981; Bieber, Pasewark, Bosten, & Steadman, 1988; Hodgins 1983; 1987). Rice, Harris, Lang, and Bell (1990) compared the recidivism rates on release of insanity acquittees with a group of convicted offenders, who were matched on the variables of age, index offence and criminal history. Recidivism rates were higher, for the convicted group. In both groups, past criminal and antisocial behaviour, were negative predictors of a good outcome. The authors argued that the relatively low rate of recidivism of insanity acquittees, was related to the fact that diagnoses of personality disorder, were much less frequent amongst insanity acquittees. Rice et al. (1990) also found no difference, in the recidivism rates of insanity acquittees and convicted offenders, when only those in both groups who had a diagnosis of personality disorder were considered. While it is likely that, insanity

acquittees are monitored more closely on release than convicted offenders, it is also probable that, hospital treatment reduced the recidivism of those who were psychotic, but not those who were personality disordered. In developing this line of research, Rice and Harris (1992) compared the recidivism rates of schizophrenic insanity acquittees, with a matched group, who had been psychiatrically evaluated. The schizophrenic group were less likely to offend over a seven year period. Score on the Psychopathy Checklist (Hare, 1991) was most closely related to recidivism, in both groups, as were variables relating to past history of offending, and alcohol abuse. In their 1995 study, these researchers found that while schizophrenia was inversely related to recidivism, again psychopathy and alcohol abuse were most closely related to recidivism.

As well as being at risk of offending whilst in the community, insanity acquittees are also likely to be rehospitalised. Golding et al. (1989) reported a 63% 'failure' rate during outpatient supervision, which was marked by an average of 2.4 rehospitalisations. Of the carefully monitored sample, reported by Bloom et al. (1992), 82% of insanity acquittees discharged from hospital had some subsequent involvement with mental health services and 69% were rehospitalised, frequently on an involuntary basis. There was no significant difference, between the average time spent hospitalised, before and after, the insanity finding. In their five year follow-up of discharged insanity acquittees, Bogenberger et al. (1987) reported that 41% were hospitalised under civil statutes, which they interpreted in light of high rates of fluctuating and severe mental illness.

Summary

- (1) *While some debate continues in the literature, psychopathy and the predictors of recidivism amongst the general criminal population appear to best predict recidivism amongst insanity acquittees also.*
- (2) *The social adjustment of insanity acquittees following discharge is poor.*

1.3 DISABILITY

1.3.1 Theoretical issues

The term 'disability', like insanity, is a legal one. It has a statutory definition, which is outlined below (chapter 1.3.4). The concept of disability, contrasts with insanity, in that its purpose is to ensure procedural fairness. 'Disability' is a New Zealand term that equates with fitness to plead in other jurisdictions. It also equates, more or less, with the American terms 'competency to stand trial' and 'competency to plead'. While there are clearly definitional issues, the concept refers to the defendant's ability to undergo the criminal process. It is distinct from other competencies in American jurisdictions, such as competency to confess, and competency to waive rights to counsel (Melton, Petrila, Poythress, & Slobogin, 1987). Disability also equates with lack of fitness to plead in other jurisdictions.

Legal standards generally involve the presence of mental illness or disorder, which impacts on the person's ability to function in court. Mental illness or disorder is necessary, but not sufficient, for a finding of disability. Grisso (1992) has identified the abilities to communicate a choice, to understand relevant information, to appreciate the situation and its consequences, and to rationally manipulate relevant information, as those that are most frequently included in legal standards. Terms such as 'substantial', 'rational', and 'adequate' are in some cases, included as modifiers. The core questions are whether the defendant can make a plea, understand the proceedings, and communicate with his or her lawyer.

The legal system, both in New Zealand and overseas, provides little detailed specification of the abilities and standards, required for adequate participation in the trial process. As a consequence, disability and incompetence have not been operationalised in psychology or psychiatry (Roesch, Ogloff, & Golding, 1993). Part of the difficulty is that, as with insanity, the determination of disability involves threshold decision making. Placement within mental health or criminal justice facilities, is a consequence of these decisions. Many factors influence the functioning and interaction of these two systems, including political trends and resources, which

change over time. In a feedback loop, mental health and criminal justice authorities, will likely have some impact on determination of the threshold. Freckleton (1995) argued that:

“A criterion for assessment should be upon whether the impact of their intellectual disability or psychiatric impairment means that they are significantly prejudiced as criminal defendants, as compared with persons not suffering such disabilities.”

(Freckleton, 1995, p.28)

He advocated for detailed clear articulation of the criterion, with a focus on functional impairments, thus avoiding the potential detrimental use of labels, such as mental illness or mental disorder.

Traditionally mental health professionals have conducted clinical assessments of competency, and made recommendations to the courts who hold responsibility for the ultimate decision. Roesch et al. (1993) described many of the American assessments as focused on the defendant's overall mental status, and findings of psychosis, or intellectual disability, with concluding statements with regards competency. Roesch et al. argued that there has often been little attempt to relate mental status factors to the specific, functional legal requirements. Part of the issue is the lack of definition and precision, in the use of the concept.

Competency has generally been approached in an unidimensional manner. However, both Golding and Roesch (1988) and Ogloff, Wallace, and Otto (1991), have proposed that it is better thought of as a multidimensional construct, involving a number of different abilities in context. Some cases are more complex, and therefore require more of the construct of competency. For example, a case of straightforward burglary is likely easier to understand, than a case of complex white-collar crime. Disability is an ‘open-textured’ concept, dependent upon seriousness, and complexity.

Additionally, there is a lack of normative information available with regards defendants who are not under disability, or incompetent. Consequently there is little known about requisite standards, boundaries and limits, which would be useful in evaluating disability. Little is known about the average criminal defendant, in terms of what abilities and knowledge they have, that the

person under disability is regarded not to have. The fact that functional abilities change over time, is a further complication. A person who is acutely and floridly psychotic may be under disability, yet relatively soon after with appropriate medication, may become fit to plead. The abilities of others, particularly those who are intellectually disabled, are unlikely to change rapidly over time.

Summary

- (1) *While there are definitional problems, it has been clearly established that a defendant must be able to participate in his or her criminal hearing.*
- (2) *Mental disorder is important, only to the extent that it impacts on the defendant's ability to function in court.*
- (3) *Disability is a multi-faceted construct.*

1.3.2 History

The current New Zealand statutory definition of disability has its origins in English common law, dating back probably to at least the eighteenth century, and possibly earlier. There is some debate amongst scholars, with regards the precise date of the emergence of this concept, however, most for example, Stiltner and Tullis (1977) and Roesch et al., (1993), have reported that by the eighteenth century, it was clear that the English courts, were employing competency doctrines.

It appears that the concept developed from medieval courts of law, which traditionally commenced, with the taking of a plea. Anglo Saxon jurisprudence, placed great weight on the concept of the plea, as a way of ensuring that there is clarity in the relationship, between the courts and the defendant. If the defendant cannot follow and understand the legal proceedings, then he or she is unable to plead. It has been regarded as fundamentally unfair to put to trial, an individual who could not properly defend him or herself. Melton et al. (1987) proposed that the emergence of competency doctrine, was also a pragmatic response to those who refused to make the required plea. When an individual was mute, and did not enter a plea, the early courts had to decide whether the defendant was 'mute of malice' or 'mute by visitation from God' (Melton et

al., 1987). Case law evolved mainly with reference to deaf mutes who were physically unable to communicate. In response to jurisprudential concerns about the fairness of the trial process, it came also to include the 'lunatic'. By the nineteenth century, courts also had to decide whether defendants could conduct a 'defence with discretion'. (Whitlock, 1963). Any person, who was found unfit to plead, was held indefinitely in an asylum. This was expanded to include intellectual functioning, and thus the legal system came to include cognition, and understanding in the determination of these matters.

While the concept has been interpreted, and used in a number of ways in different jurisdictions, a clear legal principle has developed from both constitutional and criminal law, and jurisprudential analyses, that a defendant's involvement in his trial is necessary to ensure that it reaches accurate results. An adversarial system of justice is based on the fundamental assumption that the defendant has a rational awareness of the proceedings and is able to conduct a defence. It would, therefore, be unfair to proceed against a defendant, who because of their physical or mental impairment, was unable to comprehend proceedings and to conduct their defence, in comparison with those who were not so impaired. In addition, the concept in a slightly different manner than insanity, provides a moral justification for the imposition of any punishment. Trial against a person, who was unfit to plea, would threaten the authority of and respect for the criminal justice system.

Summary

- (1) *A defendant's ability to plead, has long been held as fundamental to the legal process. While it is a poorly defined concept, it is critical in ensuring procedural fairness during criminal trials.*
- (2) *Some defendants who are under disability are psychotic and their competency can be restored. Others are intellectually disabled and their abilities are unlikely to change over time.*

1.3.3 International perspectives

England

The Criminal Procedure (Insanity and Unfitness to Plead) Act, 1991 allows for a finding that the defendant is not fit to plead. It must be followed by a 'trial of facts'. A separate jury determines the actus reus component of the case, that is, whether the defendant carried out or omitted, the criminal behaviour under question. If this is not proved, the defendant is fully acquitted. If it is proved a conviction is not made, and the range of psychiatric disposal options is the same as those for insanity. Grubin (1991) reported that about half of all those found to be unfit to plea, are eventually returned to court for trial.

America

All federal and state jurisdictions, require the defendants be competent to stand trial, prior to the commencement of criminal proceedings. While specific criteria vary, the Supreme Court has held that:

“the test must be whether he has sufficient present ability to consult with his lawyer, with a reasonable degree of rational understanding, and whether he has a rational, as well as a factual understanding, of the proceedings against him.”

(Dusky v United States, 3653, US 402 ,1960)

Thus a mental illness per se, has relevance only as it impacts on the person's rational understanding of court process.

With regards to federal matters, the Comprehensive Crime Control Act, 1984 has revised this standard. It requires that:

“the defendant is presently suffering from a mental disease or defect, rendering him mentally incompetent, to the extent that he is unable to understand the nature and consequences of the proceedings against him, or to assist properly in his defence.”

(s. 4241 US Code, Title 18)

When a defendant is found to be incompetent to stand trial, he or she is sent to a forensic psychiatric hospital, with the aim of restoring competency. Case law has established that this can

be only for a 'reasonable' period of time. This has increased the focus on treatments aimed at restoring competency (Bartol & Bartol, 1994).

Australia

The Mental Impairment Bill, 1994, outlines the statutory standards:

"A person is mentally unfit to stand trial for an offence if the person's mental processes are so disordered or impaired that the person is:

- (a) unable to understand the nature of the charge; or
- (b) unable to plead to the charge and to exercise the right of the challenge; or
- (c) unable to understand the nature of the proceedings (namely, that it is an inquiry as to whether the person committed the offence); or
- (d) unable to follow the course of the proceedings; or
- (e) unable to understand the substantial effect of any evidence that may be given in support of the prosecution; or
- (f) unable to make a defence or answer the charge."

(s. 3 Mental Impairment Bill, 1994)

As Freckleton (1995) has commented, the role of rationality remains unclear, and there is little qualification of the terms, except in (e). The extent of ability necessary to participate in the trial process, remains unknown. In Queensland, once a finding is made that a defendant is unfit to plead, the Patient Review Tribunal makes all future decision making. In New South Wales, provision exists to ensure that those found unfit for trial, will not be detained for any longer, than if they had been found guilty. The Mental Health (Criminal Procedure) Act, 1990, of New South Wales, provides for a special hearing in front of a jury as close as possible to a real trial, in which it is assumed that the person pleads not guilty. It must be proven on the evidence available, that the person committed the offence. If it is found that the person did commit the offence, then it must estimate the appropriate sanction and this becomes the 'limiting term'.

Other countries

In Canada, mental disorder is necessary, but the emphasis is on the defendant's understanding, and capacity for communication. Every two years, the court holds an inquiry to determine whether there is sufficient evidence, to put the defendant on trial. Harding (1993)

reported, that the concept of fitness to plead, hardly exists in Austria, Bulgaria, Denmark, and Switzerland. However, on psychiatric recommendation a person could be hospitalised. He or she would not be brought to trial even at a later date, and therefore would not be subject to punishment.

Summary

- (1) *While there are considerable variations in the definition of fitness to plead, and even the label given to the concept, most jurisdictions recognise that a defendant must be able to participate in his or her trial.*
- (2) *Definitions consistently refer to the functional impact of mental disorder.*
- (3) *In England, it is established whether the person carried out the behaviour under question, however this does not occur in all jurisdictions.*
- (4) *In some jurisdictions, a defendant can be returned to court following restoration to competency.*
- (5) *There is variability with regards the issue of how long a defendant can be detained for.*

1.3.4 New Zealand law

The importance of defendants' ability to take a part in legal proceedings, has been affirmed in s 25 (a) of the New Zealand Bill of Rights Act, 1990, which refers to 'a fair and public hearing by an independent and impartial court'. The statutory definition of disability, is found in section 108 CJA, 1985:

"...a person is under disability if because of the extent to which that person is mentally disordered, that person is unable

- (a) to plead; or
- (b) to understand the nature or purpose of the proceedings; or
- (c) to communicate adequately with counsel for the purposes of conducting a defence."

(s. 108 CJA, 1985)

In New Zealand as in other jurisdictions, the legal definition emphasises the impact of mental disorder on the defendant's ability to take part in the proceedings.

The legal definition of mental disorder is taken from the MHA, 1992, and is outlined below (chapter 1.5.3). It contains the notion of abnormality of state of mind, leading to dangerousness, or inability to care for oneself. The application of this definition in considerations of disability, especially when the defendant is intellectually disabled, or organically impaired, is extremely questionable. The MHA, 1992 definition of mental disorder, was specifically developed to be narrow and it specifically excludes intellectual handicap (s. 4 (e) MHA, 1992), as a justification for compulsory assessment and treatment. The courts when considering the issue of disability, rather than compulsory assessment and treatment, have made a broader interpretation of mental disorder, and held that it does include intellectual disability (Law Commission, 1994). The justification for this is, that it enables justice to be done. Boshier (1995) proposed, that the narrower definition has at times been used, specifically to exclude those with intellectual disability. The focus particularly of the medical profession has been on those whom they regard could potentially be assisted therapeutically with psychotropic medication, and this excludes those with intellectual disability.

The MHA, 1992 definition includes the necessity of dangerousness, or diminished self care, which are largely irrelevant to the concerns for procedural fairness, implicit in the concept of disability. This situation appears to have arisen, because in the development of the CJA, 1985, reference was made to mental disorder, as defined in the earlier Mental Health Act, 1969, which included intellectual disability. The consequences for disability hearings of the revision of the definition of mental disorder in the MHA, 1992, do not appear to have been fully considered.

Legal revision of this area, is currently being considered in New Zealand. There appears to be some agreement, that findings of disability should not depend on the MHA, 1992 definition of mental disorder, and that it would not be appropriate to amend the definition of mental disorder, to include intellectual disability (Law Commission, 1994).

Section 109 of the CJA, 1985 allows for a finding of disability to be made at any stage during the trial process, if it is indicated. Generally, however, the gross impairment in the functioning of defendant which is necessary for them to be under disability, usually results in a

special disability hearing, prior to the formal trial. Questions with regards the defendant's fitness to plead are determined at this disability hearing and are decided by the judge (s. 111 CJA, 1985). Disability hearings are largely inquisitional, and there is no clear standard of proof required. While the judge must be satisfied on the evidence of two medical practitioners, and after giving the prosecution and the defence the opportunity to be heard, and to call evidence on the matter (s. 111 (1) CJA, 1985), consideration is also made at this time as to whether a period of further remand, during which the mental status of the defendant might improve, rendering them fit to plead is warranted (s. 110 CJA, 1985). This usually applies to acutely psychotic defendants, who are likely to respond to medication.

Once a finding that a defendant is under disability is made, disposal options are similar to those available upon a finding of insanity and like insanity are decided with reference to 'safe(ty) in the interests of the public' (s. 115 (2) CJA, 1985). The judge may make an order for the defendant's immediate release (s. 115 (2) (b) CJA, 1985), or decide not to make an order (s. 115 (3) (c) CJA, 1985). Section 115 (2) (a) CJA, 1985 allows the judge to 'make the order that the person be detained in hospital, as a committed patient'. The consequence of a section 115 (2) (a) CJA, 1985 order, is that the defendant cannot be brought back to court, on the same charges. He or she is committed to a psychiatric hospital, in a functionally equivalent manner as a compulsory inpatient treatment order (s. 30 MHA, 1992). The person's responsible clinician then makes decisions as to when they can be released from hospital.

In cases where the defendant found to be under disability faces serious charges, or the person is regarded as dangerous, they may be held as a special patient pursuant to section 115 (1) (a) CJA, 1985. If there is no change in mental state and the person's ability to plead, the 'special patient' status continues for:

- “(a) seven years (from the date of making the order) in a case where any offence charged was punishable by imprisonment for life or preventative detention; or
- (b) a period equal to half the maximum term of imprisonment to which the defendant was liable on conviction.”

(s. 116 (1) CJA, 1985).

Thus, in contrast to the insanity provisions, there is limitation on the period of confinement. In cases where the person, over time improves, and is regarded to be no longer under disability, the Attorney General may direct that the former special patient be held as a committed patient (s.116 (5) CJA, 1985). Discharge from hospital is subsequently determined by the person's responsible clinician, or the defendant may be brought back to court for trial (s. 116 (4) CJA, 1985). This is in contrast to insanity acquittees who once the court has disposed of the defendant, this is the end of the matter, and the case cannot be reheard.

Chaplow (1995) has pointed out some difficulties with the current situation. He has argued that the admission thresholds used by the courts and hospitals, which frequently have to prioritise admissions, may be at variance. Under law a special or compulsory patient, may have been found under a disability, yet it may not be possible to detain them upon review. Section 35 of the MHA, 1992, specifies that if a person is 'fit to be released from compulsory status', then this must occur, and section 2 defines this phrase as meaning 'no longer mentally disordered, and fit to be released from the requirements of assessment and treatment under this Act'. The issue is whether the test for release from the mental health system is the same as that for admission. An intellectually disabled person may be considered mentally disordered for the purposes of a disability hearing, but it is unclear whether this also applies to discharge. The Law Commission (1994) recommended that if a person is found to be under disability, that the courts then determine whether the defendant is dangerous, and if so, that they be held as special or committed patients. It follows that the components of review be altered in accordance with these admission criteria. If a defendant is under disability, but not mentally disordered, or dangerous, the Law Commission (1994) has proposed that, the courts make an order for his or her immediate release. The Protection of Personal and Property Rights Act, 1988, which authorises a variety of residential and other orders, might in some cases be used when there are concerns about the person's independent living skills.

Currently in New Zealand a person found to be under disability, may be detained for many years without proof that illegal behaviour occurred, or they were physically responsible for

it, that is, the actus rea. This is somewhat contradictory, in that the outcome of laws designed to protect the rights of defendants to a fair trial, may be long term detainment in a psychiatric hospital, which is not necessarily in the person's best interests. The Law Commission (1994) recommended that consideration be made, into the possibility of holding a special hearing, after a finding of unfitness to stand trial, to establish the defendant's innocence of or factual responsibility for the alleged crime.

Summary

- (1) *The application of the definition of mental disorder, taken from the MHA, 1992, to determinations of disability is problematic, especially when the defendant is intellectually disabled.*
- (2) *Revision is currently being undertaken in this area.*

1.3.5 Empirical characteristics of those found unfit to plead

As mentioned above, much research has used mixed samples of insane and incompetent defendants, however Steadman (1979) provided a narrative review of the earlier literature, of the variables associated with incompetence to stand trial. He described defendants who were unfit to stand trial as being 'marginalised', and with few social and economic resources. They tended to have less education, skills, and social support, than those found to be competent. Referral for crimes related to violence, were more common, as were high rates of psychiatric morbidity. Reich and Wells (1985) similarly concluded that, relative to competent defendants, those found to be incompetent tended to be black, unmarried, and less educated. They had more previous psychiatric hospitalisations and were more likely to be psychotic.

Nicholson and Kugler (1991) reviewed and compared studies in a meta analytic manner. The magnitude of relationships was determined and averaged across studies. In this review women, members of minority ethnic groups, older defendants, those who had never been married, and those with a history of prior psychiatric hospitalisation, were more likely to be judged incompetent, however, these variables accounted for only a small percentage of the variance. In contrast to the research findings with regards insanity, those that had no history of legal involvement, were more often found to be incompetent. The authors suggested that it is the entire group of referred individuals, that have poor social, and economic resources, rather than specifically those found to be incompetent by the courts.

In the Nicholson and Kugler (1991) review, type of offence was not correlated with findings with regards competency. It appeared that offence type, was more closely related to the decision to refer for evaluation, than to competency per se. Berman and Osbourne (1987) found that defendants, charged with more serious crimes, were more likely to be referred, than those charged with minor crimes. Melton, Weithorn, and Slobogin (1985) reported a similar finding.

The correlation between diagnoses of psychosis and incompetence, across studies was consistently strong. However, of those subjects with a psychotic diagnosis, only half were found to be incompetent. The correlation between intellectual impairment, and incompetence was weak.

Daniel and Menninger (1983) reported that those with mild mental retardation are often able to meet minimal competency standards, and it is likely that this reduces the overall relationship between mental retardation, and incompetence. Psychiatric symptomology was also reviewed in the Nicholson and Kugler (1991) study. Symptom categories significantly associated with incompetence were, disorientation, delusions, hallucinations, impaired memory, impaired thought or communication, and disturbed behaviour. The authors proposed that these symptoms reflect cognitive and behavioural impairment. Affective disturbance and impaired judgement, were not related to competency.

Of the variables studied by Nicholson and Kugler (1991), poor performance on instruments designed to assess legal relevant functional abilities, was most strongly associated with incompetence. Examination of effect sizes, showed that scores on the Competency Assessment Instrument (Laboratory of Community Psychiatry, 1974; McGarry & Curran, 1973) and the Interdisciplinary Fitness Interview (Golding, Roesch, & Schreiber, 1984; McDonald, Nussbaum, & Bagby, 1991), produced the most valid results followed by the Georgia Court Competency Test (Wildman, Batchelor, Thompson, Nelson, Moore, Patterson, & de Losa, 1978) and the Competency Screening Test (Lipsitt, Lelos, & Mc Garry, 1971). To a lesser but significant extent, performance on traditional psychological tests, including IQ tests and the MMPI were also related.

An aim of the Nicholson and Kugler (1991) review, was to examine empirically the validity of the legal construct of competency. They argued that differences between defendants found competent and incompetent, with regards diagnoses and performance, on specifically designed tests were to be expected. The small but significant associations between demographic characteristics, and competency may well have reflected biases in decision making. The theoretical relevance of variables such as age, sex, and race to competency decisions, remains unclear.

There has also been a series of studies, comparing the relative power of variables in predicting competency. Results have been inconsistent, and this is usually attributed to

differences in methodology, particularly measurement devices, and differences in legal practices between jurisdictions. Daniel et al. (1984) and Roesch (1979) reported that clinical characteristics were more important than psycholegal ability in predicting competency. Hart & Hare (1992) using discriminant function analysis, also found that diagnostic variables discriminated best between competent and incompetent defendants. Other clinical, demographic, and criminal variables did not improve on prediction, using diagnostic variables alone. In a study by Rogers, Gillis, McMain, and Dickens (1988), however, which also employed multivariate statistics, demographic variables such as age, race, and gender, performed as well as clinical variables, in predicting competency. The results of two studies (Golding et al., 1984; Roesch, Jackson, Sollner, Eaves, Glackman, & Webster, 1984), suggested that both psycholegal ability, and diagnosis were important in predicting competency. Nicholson and Kugler (1991) commented that this is consistent with the theory of competency. Psycholegal ability is most important, however mental status and diagnosis, provided a legitimate basis for finding that a defendant is unfit to stand trial.

Summary

- (1) *Defendants who are found to be incompetent, or unfit to plead, are similar to those found to be not guilty by reason of insanity, in that they are frequently socially disadvantaged.*
- (2) *Also like insanity, diagnoses of psychoses are related to lack of fitness to plead.*
- (3) *Both clinical variables and psycholegal variables have been found to be predictive of competency.*

1.3.6 Reliability and validity

Both Roesch & Golding (1980), and Golding et al. (1984) reported that pairs of mental health evaluators, agree in over 80% of cases, with regards to competency to stand trial. As with insanity, it is important to consider base rates, however, in that most defendants who are referred for evaluation are clearly competent, so high rates of agreement will occur.

Predictive validity is difficult to assess because of the interaction, between legal decisions and outcome and there are no absolute standards. Defendants found to be incompetent, do not proceed to trial, so their competency is never truly tested in a legal setting. It is clear however, that courts rarely disagree with the recommendations made by mental health professionals. Rates of agreement consistently exceed 90% (Appelbaum, 1984; Hart and Hare, 1992; Melton, et al., 1986; Nicholson and Johnson, 1991; Reich and Tookey, 1986). Reich and Tookey (1986) examined those cases where there was clear cut disagreement between the decisions of the court and the psychiatric recommendations. In all cases, mental health professionals regarded the defendants as incompetent, while the court did not. This suggests that there may be a tendency for psychiatric evaluators, to overestimate the extent of necessary functioning. Appelbaum (1984) argued that the court may be reluctant to interfere with the decision making of mental health professionals, and therefore defers to its expertise. Hart and Hare (1992) added to this, by emphasising that clinical impressions are difficult to evaluate. Clinical experience and discretion, which appear to be the basis of recommendations to the courts are all difficult to examine objectively in court, especially given the nature of vague, legal formulations on the matter.

Summary

- (1) *There appears to be relatively high rates of agreement, with regards to fitness to plead, between assessors.*
- (2) *As with the insanity defence, the courts usually follow the recommendations of mental health professionals.*

1.3.7 Clinical assessment

As with insanity, when questions with regards to fitness to plead arise, the courts usually call for expert evidence from mental health professionals. Like insanity also, the task of assessing fitness to plead is fundamentally different from the work of most mental health professionals, who are oriented towards clinical assessment and therapy, rather than specific assessment of a defendant's ability to function within a legal forum. Standardised assessment methods have not been used within New Zealand. This is likely because of concerns, with regards to differences in legal standards, and cultural factors. Most assessments in New Zealand are nonstandardised and clinical in nature, at times supplemented by the results of general psychometric testing.

Beginning in the 1960s however, a number of standardised methods for evaluating competency became available in the United States. Harvard Medical School's, Laboratory of Community Psychiatry, pioneered this development, with the publication of the Competency Screening Test (CST) (Lipsitt et al., 1971). This instrument was designed for screening defendants, for indications that more detailed institutional assessment was warranted, and the Competency Assessment Instrument (CAI) was developed, for more complete evaluation (Laboratory of Community Psychiatry, 1974; McGarry & Curran, 1973).

When using the CST, defendants are asked to complete 22 sentences describing hypothetical legal situations, for example, 'If the jury finds me guilty....'. Responses are rated 2 (competent), 1 (questionable competency), or 0 (incompetent). Lipsitt et al. (1971) in the manual guidelines recommended a cut off of 20 or below as indicative of possible incompetence and that the defendant requires further evaluation.

Interjudge reliability has been shown to be good, with reliability coefficients consistently above .9 (Lipsitt et al., 1971; Nicholson, Robertson, Johnson, & Jensen, 1988; Randolph, Hicks, & Mason, 1981). Randolph et al. (1981) also reported that, the agreement with the CST and mental health professional decisions was 71.2%, with a low number of false-negatives and most errors false-positives. Thus it tends to over-predict incompetence, which is the desired direction for tests of this nature, given that further assessment will occur. The study by Nicholson et al.

(1988) reported significant correlations with diagnoses of mental retardation, years of education, and race, but not diagnoses of psychosis. They regarded this as reflective of the intellectual aspects of competency.

Criticisms of the CST have focused on the underlying values in the scoring method (Nicholson & Kugler, 1991). With the item 'Jack felt that the judge...', responses suggesting fairness are scored 2, while responses such as 'too harsh' or 'wrong' are scored 0. The CST also requires the ability to read and write, which is often a difficulty in assessing the questions of competency (Chellsen 1986). Nicholson and Kugler (1991) concluded that the CST appeared to function 'reasonably well' and suggested that it is perhaps not used as widely as a screening device, as it might be, because the vast majority of referred defendants, are in fact competent to stand trial.

The CAI uses a structured interview format to assess 13 'legally relevant' areas, such as 'knowledge of courtroom procedures', and 'quality of relating to attorney' (McGarry & Curran, 1973). Grisso (1986) in reviewing the instrument, noted that there has been no empirical establishment of these 13 functions. Defendants' responses in each area are rated on a five point scale ranging from one (total incapacity), to five (none). Manual guidelines provide suggested questions and examples, however, there are no clear rules for translating interview responses into overall decisions with regards fitness to stand trial. Research on the reliability and validity, of the CAI is limited. A study by Roesch and Golding (1980) however, with a sample of only 30 cases found interrater reliability to be 81%, and there was 70% agreement between interviewers' judgement and decisions based on detailed hospital evaluations. Commentators agree that the CAI has probably been used more as an interviewing structuring device, than in the manner intended by its authors in that its results are often integrated with other aspects of the assessment and it is rarely used as the only assessment method (Ogloff et al., 1993; Golding & Roesch, 1988). Further research is clearly needed.

The Interdisciplinary Fitness Interview (IFI) (Golding et al., 1984; McDonald et al., 1991) is another structured interview, designed to be administered jointly, by legal and mental

health professionals. Questions cover five legally relevant abilities, and 16 areas of psychopathology, leading to an overall evaluation, and a consensual judgement. The IFI was designed, such that evaluators consider mental status issues, in relation to their role in legal situations. In an example provided by Ogloff et al. (1991), a defendant with hallucinations might receive a low weight score if it was regarded that the hallucinations did not impact on the legal case, however, another defendant with similar clinical symptomology, would receive a high weight score if the hallucinations were regarded as being potentially problematic in court. In the study by Golding et al. (1984) there was 97% agreement between ratings made by lawyers, and either psychologists or social workers. There was 76% agreement between detailed hospital assessments, and overall judgements using the IFI.

Other instruments designed for assessing competency, include the Georgia Court Competency Test (GCCT) (Wildman et al., 1978) and its revision the Georgia Court Competency Test – Mississippi State Hospital (GCCT-MSH) (Nicholson, Brigg, & Robertson, 1988; Johnson & Mullet, 1989). Both aim to provide a rapid quantitative measure, and focus on legal abilities rather than psychopathology. The Competence Assessment for standing Trial for Defendants with Mental Retardation (CAST-MR), was designed by Everington (1990), for use with intellectually impaired defendants.

Summary

- (1) *As with insanity, there are a number of structured measures available for assessing fitness to plead.*
- (2) *They are not used in New Zealand, because they have been developed to meet legal standards in American jurisdictions.*

1.4 GUILTY AND MENTALLY DISORDERED

In comparing the insanity defence internationally (chapter 1.2.3), mention was made that many jurisdictions have introduced a third, halfway option between insanity and complete culpability. English law contains the notion of diminished responsibility in homicide cases (Homicide Act, 1957). Walker (1968) investigated the impact of this legislative change, and found that while the proportion of defendants avoiding a murder conviction on psychiatric grounds (unfitness to plead, insanity, or diminished responsibility) remained constant, it greatly reduced the number of unfitness to plead and insanity pleas. Diminished responsibility is also available in Australia, in cases of homicide, and in some American jurisdictions. This option is currently being debated in New Zealand.

The guilty but mentally ill finding is another way, with which a different option has been introduced in some American jurisdictions. While some States have abolished not guilty by reason of insanity as a separate defence, and use this alternative, nine other states have a guilty but mentally ill verdict, as well as the insanity defence (Bartol & Bartol, 1994). The specific definitions of guilty but mentally ill varies by State, but most require the determination of mental illness, at the time of conviction, using the same or similar criteria as those for civil commitment. Empirical studies have consistently shown, that the introduction of these options, significantly reduces the number of defendants, who are found to be not guilty by reason of insanity (Finkel & Duff, 1989; Roberts & Golding, 1991). What is less clear, as Finkel and Fulero (1992) have suggested, is whether these changes reflect 'coherence, compromise or chaos'. There have been criticisms also, of these options as an easy way out of avoiding the difficult moral issues, inherent in the determination of guilt (American Psychiatric Association, 1983).

Hospital orders pursuant to section 118 CJA, 1985 have no formal title in New Zealand and their historical origins are unclear and poorly documented. In the current study the technical title of guilty and mentally disordered has been referred to. The fact that the common usage (s. 118 CJA, 1985) is to the specific section of the relevant Act, rather than to a more general concept, is likely a reflection of the ambiguous nature of these hospital orders.

Any person who is convicted of a criminal offence in New Zealand, can be sentenced to a psychiatric hospital, under section 118 of the CJA, 1985, which states that:

“...when a person is convicted of an offence, the court, on being satisfied by the production of a certificate by two medical practitioners, that the person is mentally disordered, and that his or her mental condition requires that he or she should be detained in a hospital, either in his or her own interest, or for the safety of the public, may, instead of passing sentence, make an order that the person be detained in hospital as a committed patient.”

(s. 118 CJA, 1985)

The definition of mentally disordered is taken from the MHA, 1992 (see chapter 1.5.3). This option is distinctly different from a finding of not guilty by reason of insanity, or that the accused is under disability, in that it requires determination of guilt. As with other hospital orders, judicial review is necessary, but there is no requirement of personal consent. Decisions about its possible applicability in individual cases are made by weighing up the interests of the offender, the public interest, and the seriousness of the offending (Brookbanks 1996c).

There has been some debate with regards the seriousness of the offences for which a section 118 CJA, 1985 hospital order might be applicable. Brookbanks (1996c) stated that while there is no statutory requirement, in practice this option is used, most frequently, when the offender has been charged with an imprisonable offence. However, in cases where the offending is very serious and the public would be at risk, if the person was in the community, the use of section 118 CJA, 1985 orders has also been regarded as inappropriate. This is likely because of the possibility of community discharge, if the person quickly stabilises on medication, and ceases to be mentally disordered as defined under the MHA, 1992. Case law has also established, that hospital orders of this nature are inappropriate, when the offence is minor and the indeterminate nature of committal, would constitute a penalty out of proportion to the offence. In these cases the use of the MHA, 1992 is more suitable.

Only two New Zealand studies are available which comment on guilty and mentally disordered disposal options, in New Zealand. Tollefson (1993) challenged, what he regarded as

public concern, that the guilty and mentally disordered option was being applied to dangerous offenders, who were soon discharged and quickly reoffended. He studied the use of these orders, over a five year period, between 1985 and 1991. Because the court disposed of some people more than once during this time period, 293 orders were made against 261 people, with an average of 47.2 per year. Of these people, 242 were male and 19 female. The 830 convictions covered a wide range of crime types, including murder, attempted murder, and offences against public order, and justice, and public morals.

Of the 171 traced files, 84.8% were released on leave, or discharged at some time during the five year study period, however, only 15.9% were discharged outright. The length of stay, prior to first release, either on leave or discharge, ranged from one day to 1,637 days, with a median of 57 days. Reconviction during leave or discharge occurred for 40.7% of those who were released. In 15 cases this occurred within a month of release. Of the remaining 44, the average time to reoffending was 13 months. There was no evidence that those released earlier, were more likely to be reconvicted. A number of those who were not reconvicted, had their leave cancelled and were readmitted or civil commitment occurred. The 59 recidivists had 838 convictions, which implies that they are involved in a high rate of crime. While a similar range of crime, was involved in the recidivist offending, overall there were less violent offences and more property offences. Tellefson (1993) also called for, more clarity about the purpose of these hospital orders, especially with regards public safety, and the rights of the individual.

McElrea (1992) argued that there is an inherent conflict between the objectives of punishment and treatment with section 118 CJA, 1985 hospital orders, and this is the reason for the relatively little use, that is made of it. Because the court, may commit to an institution instead of passing sentence, McElrea proposed that it is therefore an alternative to imposing a sentence. The courts have at times however, appeared to treat section 118 as a sentence, that is, as a type of detention and punishment. McElrea regarded that the 'instead of' suggests that sometimes, it may be inappropriate to sentence someone who is mentally disordered, when their ability to understand is seriously affected, or there is a psychiatric explanation for offending, or treatment might reduce

reoffending. Its use therefore, is applicable when sentencing is inappropriate. McElrea has pointed out that if the guilty and mentally disordered option is regarded in this manner, there is no clash with the usual sentencing principles, when psychiatrists deal with leave and discharge as occurs under this option. The fairness of confining a person to hospital, from which they may soon after be released, when they would otherwise be sentenced to prison, given the well established legal principle, that like cases are treated alike, was a proposed reason for its low level of use. The issues relating to the seriousness of the charge, to which this disposal might be appropriate, are an additional reason, as are patient preferences. Defendants might prefer a finite prison term, with little or no conditions on release, to hospital admission with no predetermined time of discharge, and stringent follow-up conditions.

McElrea (1992) recommended that the courts, pass sentence in usual manner, and then suspend the sentence, for as long as the person is a committed patient. Judges therefore, would not have to anticipate medical decisions, and could use the usual sentencing principles with reference to public safety, and psychiatrists would not be responsible for release decisions. The separate nature of punitive and therapeutic aims, would thus be recognised.

Summary

- (1) *Very little research has investigated the guilty and mentally disordered disposal option.*
- (2) *It appears to be a form of half way position with regards the culpability of the individual.*
- (2) *There is inherent confusion with regards whether the aims of this option are to punish or to therapeutically assist the defendant.*

1.5 CIVIL COMMITMENT

1.5.1 History

Bartol and Bartol (1994) have reported that the doctrine in law, which establishes the right of the State to substitute its decision-making, for that of others is 'parens patrie', which translates to 'parent of the country'. It is questionably benevolent and based on the social belief that there are some people, who cannot or will not protect themselves, despite the fact that they are not directly harming others. Children and the insane are two groups that are protected by laws derived from these principles.

The ambiguous history of the concept, can be traced to Roman law, where it was applied, when the head of the family was held to be incompetent and his estate therefore would transfer to his 'protectors'. Cogan (1970) wrote that by the eleventh century, the King had the power to protect the lands of lunatics and benefit from their profits, until they achieved mental restoration, which in effect meant indefinitely.

During the early nineteenth century, there was a change from the commitment of people to asylums against their wills, to people being cured by treatment, within their safe and protected environment. Idiots, the poor, and the homeless, were held in this manner, and some of the treatments used were of dubious value. The concern or convenience of the families involved remained questionable however, and there was no requirement that mental disorder be demonstrated.

By mid 1850s, it had become clear that the State had the right to detain people who were regarded as dangerous, either to themselves or others. If these criteria were met individuals could be detained for remedial treatment against their will. The principles of dangerousness and grave disability, which questions the ability of the person to care for him or her self, underlie most current criteria for civil commitment.

The growth of the civil rights movement has also been influential in the recent development of law in this area. Most jurisdictions require the courts to review decisions with regards initial and ongoing confinement, and the presence of mental disorder must be clearly

evident to justify detention. The deprivation of liberty has increasingly become emphasised, rather than paternalistic concerns about treatment needs, and frequently the dangerousness criteria have become paramount.

Dangerousness has proved to be a difficult concept to define and legal standards vary in the precision with which they do so. Because it involves a probability estimate of future behaviour, there is invariably some error. In contrast to the criminal justice system, there appears to be more tolerance of false positive predictions within the mental health system. Research on the prediction of dangerousness has been lead by Monahan who has identified a number of methodological issues (Monahan, 1981; Monahan & Steadman, 1994a). These include impoverished predictor variables, difficulties with the specification of the criterion, sample selection, and the lack of co-ordination of research efforts. While it is a clear finding that the best predictor of future behaviour is past behaviour, and that attention to base rates improves the accuracy of predictions, the extent to which these are included in estimates of dangerousness, encompassed within civil commitment decisions is unknown.

Summary

- (1) *The historical basis of civil commitment derives from powerful people using the notion of lunacy to deprive others of their wealth.*
- (2) *It was developed with the aim of protecting those who are unable to care for themselves, however dangerousness is now a more prevalent concern.*
- (3) *The civil rights movement has recently questioned the justifications for deprivation of liberty.*

1.5.2 International perspectives

England

The Mental Health Act, 1983, of the United Kingdom defines mental disorder, and establishes the parameters of compulsory assessment and treatment in England and Wales. Patients may be compulsorily detained either for the safety of others or the sake of his or her own health. While psychopathic disorder is included in the definition of mental disorder, (s. 1 (2) Mental Health Act, 1983) people cannot be detained in psychiatric hospitals solely on this basis. There are also criterion related to dangerousness, and the psychopathic disorder must be of a nature or degree which makes it appropriate to receive medical treatment in a hospital, in order to 'alleviate or prevent deterioration of the condition'. (s. 3 (2) Mental Health Act, 1983). The emphasis on treatment suitability reflects the law of many European jurisdictions, where civil rights concerns have led to the necessity of a treatment model, either explicitly or implicitly, as a requirement of psychiatric committal.

America

In America, each State has its own laws in this area. Most allow civil commitment on the basis of mental illness and dangerousness, and there are a variety of specific definitions of these terms. Turkheimer and Parry (1992) reported that approximately thirty States also allow commitment on the basis of 'grave disability', and that these provisions are mostly applied to disturbed young people. Often they are admitted under the more stringent dangerousness criteria, and grave disability is used as a justification for ongoing confinement. Scholarly debate has focused on the admission criteria, especially when people are predicted to be dangerous, however, as Turkheimer and Parry (1992) commented, studies of the prediction of ability to care for oneself have yet to be undertaken. The application of civil commitment provisions to minor forms of dangerousness such as theft, has also been questioned, as has the right of the individual to refuse treatment, particularly psychotropic medication.

Australia

Harding (1993) reported that in Queensland, there are three forms of involuntary admission with inversely, varying degrees of complexity and urgency. The Patient Review Tribunal oversees these. Within the Mental Health Act 1983, of New South Wales, there is an emphasis on the right to treatment, community based services, and stringent standards of proof, for establishing the presence of mental illness and dangerous behaviour, as a basis for involuntary admission.

Other countries

Canada also has provincial mental health codes, which all require evidence of mental disorder, however defined. As with other jurisdictions dangerousness is a concern, and emphasis has been on the empirical criteria, that scientifically relate to the concept, and can be reliably reproduced. There is also innovative emphasis on defining safety, as a basis for discharge investigation.

Summary

- (1) *Most jurisdictions contain provisions for the involuntary psychiatric hospitalisation of persons who are regarded as dangerous, or unable to care for themselves.*
- (2) *While there are variations in definitions, mental disorder or illness must be demonstrated.*
- (3) *Psychiatric testimony is almost always called for. There has been debate as to, whether the real decision making power lies with the courts, or whether they have been essentially 'rubber stamping' the decisions of mental health professionals.*
- (4) *Some jurisdictions focus on the ability of treatment, to meet the person's needs.*
- (5) *Canada has been developing the empirical parameters of safety, as well as dangerousness.*

1.5.3 New Zealand law

Another way whereby a criminal defendant in New Zealand may become psychiatrically hospitalised is, for proceedings to be commenced under the MHA, 1992, which contains the principles of the determination of mental disorder, dangerousness and grave disability. To meet the criteria for compulsory assessment and treatment in New Zealand, the person must be 'mentally disordered' as defined in section 2 of the MHA, 1992:

“ ‘Mental disorder’, in relation to any person, means an abnormal state of mind (whether of a continuous or an intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it:

- (a) poses a serious danger to the health and safety of that person or of others; or
- (b) seriously diminishes the capacity of that person to take care of himself or herself.”

(s. 2 MHA, 1992)

While plea bargaining is not a legal option in New Zealand, there may be informal negotiation, which results in the police prosecutor agreeing to drop charges, and mental health professionals commencing proceedings under this Act. Alternatively but less frequently, the defendant may agree to a voluntary admission. Arrangements such as these, can alleviate the stress of criminal court proceedings, and there is an assurance that the person receives assistance from mental health professionals. The offences involved are usually of a non serious nature, and this arrangement would be unlikely to occur if the charges were serious or violent. Psychiatric assessment must be completed in order to determine, whether the defendant meets the criteria for compulsory assessment and treatment, before this option is proposed.

Because of differences, in the criteria for insanity, and mental disorder, a person who is acquitted on account of insanity, will not necessarily be mentally disordered within the meaning of the MHA, 1992. Major psychiatric disorder is necessary, and it must result in dangerousness or an inability to care for oneself. In essence, this option avoids the issue of culpability. Questions of mental state at the time of the crime are avoided, and the responsible clinician retains control of the person's discharge from hospital. Inability to self-care is not a justification for ongoing

containment, and community treatment is preferred to compulsory hospitalisation and is regularly assessed.

In contrast to the broad definition of mental disorder contained in English law, section 4 of the MHA, 1992 states that, the procedures relating to compulsory assessment and treatment cannot be invoked by sole reference to:

- “(a) that person's political, religious, or cultural beliefs; or
- (b) that person's sexual preference; or
- (c) that person's criminal or delinquent behaviour; or
- (d) substance abuse; or
- (e) intellectual handicap.”

(s. 4 MHA, 1992)

There is ambiguity, with regards the issue of whether antisocial personality disorder or psychopathy, is a sufficient justification for compulsory treatment, in that it is defined on the basis of criminal behaviour, and like intellectual disability, does not represent a departure from the person's usual level of functioning. Case law has held, however, that in some cases, but not necessarily, it can be regarded as a disorder of volition, and thus is sufficient justification for compulsory assessment and treatment (Law Commission, 1994).

The MHA, 1992 definition of mental disorder, specifically excludes intellectual handicap as a justification for compulsory assessment and treatment, thus reflecting changes in attitudes toward the care of intellectually disabled people, over recent decades. In New Zealand a separation has been evolving between the care of those with intellectually disability and acquired organic impairment, and those with mental illnesses. There has been marked deinstitutionalisation of the intellectually disabled, and the growth of treatments of a psychological and educational nature. Intellectually disability is not an illness in the same way as psychosis, and it is questionable whether an appropriate place of treatment is the psychiatric hospital. While a person with psychosis has deviated from his or her own norm, this is not true for those with intellectual disability. Those with psychosis also, can frequently be treated medically, and the impact of the illness reversed, however, the same is not true for intellectual disability. With regards to

compulsory assessment and treatment, the exclusion of intellectual handicap specified in the MHA, 1992, has been adhered to in the case law developed by the courts, and it is not possible to have a person assessed and treated against their will on the basis of their intellectual disability alone. In some cases however intellectual disability occurs comorbidly with mental disorder, as defined in the MHA, 1992.

Summary

- (1) *Some defendants have their non-serious charges dropped, and civil commitment proceedings are commenced under the MHA, 1992.*
- (2) *The narrow definition of mental disorder, included in this Act, has lead to difficulties in application, especially with regards people who are intellectually disabled or personality disordered.*

1.6 DIVERSION

Final decisions about the outcome of criminal cases are made within the courtroom, and there are a series of English studies, that have discussed the diversion of offenders. Within this context, the term 'diversion' means diverted from the criminal justice system, for mental health reasons, and does not necessarily mean diverted to psychiatric hospitals. It is different from the common usage of the word 'diversion' in New Zealand, which refers to the diversion of first offenders from criminal prosecution, following the completion of some form of community service. The court diversion schemes appear to have been initiated because of concern, about the inappropriate placement of some mentally ill people, within the criminal justice system.

Blumenthal and Wessely (1992) documented the rapid growth of court diversion schemes in the Magistrates' courts in England and Wales, particularly in inner city areas, following the publication of the recommendations of the Reed Committee (Department of Health and Social Security, 1992). Court diversion schemes have subsequently been encouraged by the Home Office provision of funding.

Joseph (1990; 1994) described a psychiatric service serving an Inner London Magistrates' Court. It aimed to provide psychiatric assessment, of the homeless, mentally ill, petty offender, as soon as possible following arrest, with the intention of diverting the defendant from custody. The scheme was viewed as having a number of advantages, compared with assessment in remand prisons, which had been the norm before the initiation of the scheme in 1989. Additional information was more readily available, and case processing was quicker. Joseph and Potter (1993) reported that the time spent on remand reduced from 50 day to 6 days. Discussion and liaison with police and legal counsel, was also easier. Of all those seen, 30% were admitted either informally or under the civil provisions of the Mental Health Act, 1983 of the United Kingdom, and in an additional 5% the case was discontinued on 'public interest' grounds. James and Hamilton (1991) likewise, calculated a reduction in processing time, in the provision of psychiatric report to the courts, from 51 days to nine days.

Critics such as Walker and McCabe (1973) and Smith and Donovan (1990), have pointed out some disadvantages of this diversion. It may lead to the under reporting of criminal behaviour by those with psychiatric histories, and poor recording of information, with regards the circumstances and the extent of violent crime, with subsequent future management difficulties. It also may encourage the offender to minimise or deny the impact of his or her behaviour on victims and society. Joseph (1993) questioned the consequences of diversion for the individual involved, and the efficacy of psychiatric hospitalisation, in preventing future offending. The study by Cooke (1991) suggested positive outcome, in that in some cases health care was provided to those who otherwise might not have had access to it.

Prins (1992) raised the valuable question of diverted to where? Rowlands, Inch, Rodger, and Soliman (1996) in their one year follow-up study, of court diverted defendants, in a provincial city, found that those with psychotic illnesses, gained the most benefit from the scheme, in that no people with psychosis were in prison at follow up, and most remained in contact with psychiatric services. More than two thirds, of those with other diagnoses, however, gained little benefit, and there was a high default rate, amongst those who were managed on an outpatient basis. Most defendants with substance misuse problems, quickly lost contact with psychiatric services. At follow-up most of those who were diverted were living in the community and there was a 17% reoffending rate.

Summary

- (1) *In England, there are a number of court diversion schemes.*
- (2) *The CLS in New Zealand, appears to be based on these models.*

Summary of Chapter One

- (1) *There are four ways in which criminal defendants can become psychiatrically hospitalised in New Zealand. They can be found to be insane at the time of the crime, under disability, guilty and mentally disordered, or the charges dropped and proceedings commenced under the MHA, 1992.*
- (2) *Each of these options has distinctly different historical origins, backgrounds and theoretical justifications yet functionally leads to the same position. That is, the person becomes confined in a psychiatric hospital rather than in a prison.*
- (3) *While the determination of disposal options remains within judicial parameters, most defendants who become psychiatrically hospitalised have psychotic disorders.*
- (4) *There is ambivalence as to the extent to which in reality, this confinement is therapeutic or an alternative form of social control.*
- (5) *The public is particularly concerned about this group of offenders and holds a number of erroneous myths about the circumstances of their crime, and their subsequent hospitalisation.*
- (6) *The victim's perspective is poorly considered.*
- (7) *The CLS is an initial point of contact with the mental health system, for criminal defendants. Decision-making occurs, with regards whether it is recommended to the court that psychiatric hospitalisation is appropriate.*
- (8) *Very little New Zealand research has focussed on the CLS.*

CHAPTER TWO

THE STUDY

In this chapter the New Zealand context of the study is outlined. This covers the recent development of forensic psychiatric services, of which the CLS forms a part. The specific functioning of the CLS is then described and the rationale and aims are then outlined. This is followed by a description of the method used in the current study.

2.1 THE CONTEXT OF THE STUDY

2.1.1 Forensic psychiatric services

The structure of forensic psychiatric services in New Zealand today are largely a consequence of the Mason Report (Mason, Bennett, & Ryan, 1988), and the subsequent implementation of the recommendations of this report. The then Minister of Health, Michael Bassett, appointed this commission of inquiry to review the procedures used in psychiatric hospitals in relation to mentally disordered offenders. The interface between the criminal justice system and psychiatric hospitals had been difficult in New Zealand for a number of years, especially in the Auckland area, reflecting both historical and legal ambiguity.

Prison staff viewed the frequently punitive prison environment as an inappropriate and untherapeutic place for those who were psychiatrically unwell. They had minimal training in dealing with mental disorder and were often frustrated when dealing with bizarre and challenging behaviour. The census of prison inmates conducted by the Justice Department, during 1987 (Braybrook & O'Neill, 1988), recorded that prison staff considered that 5% of male inmates, and 16% of female inmates required psychiatric hospitalisation.

Health authorities on the other hand, especially the Auckland Hospital Board regarded psychiatric hospitals as not being suitable for offenders. At this time, there were minimal specific facilities in psychiatric hospitals for mentally disordered offenders and remandees, who were frequently disruptive. It was argued that treatment in an open therapeutic environment was

compromised for all psychiatric patients, by the necessity of providing secure facilities. Health staff were not well trained in dealing with security issues, and were reluctant to accept people whom they did not feel capable of handling.

The Mason Report (1988) noted the change in the admission criteria to Oakley hospital in Auckland, for mentally disordered offenders that occurred during March 1983. Sections 42 and 43 of the then Mental Health Act, 1969 required the presence of a 'treatable mental disorder' as a prerequisite for transferring an inmate from a penal institution to a psychiatric hospital. The Auckland Hospital initiated the interpretation of this phrase in such a manner, that transfer between Paremoremo Maximum Security prison and Oakley hospital became virtually impossible. Policy in the remainder of the country however, was largely unchanged.

Between March 1983 and December 1987 there were 13 suicides of inmates at Paremoremo, in contrast to the one suicide between December 1968 when the prison opened, and January 1983. This was accompanied by corresponding increases in hanging attempts and self mutilatory behaviours and it was noted that many of those who committed suicide were of Maori descent. Both the Mason Report (1988) and Skegg (1992) who reviewed this information, concluded that difficulties in gaining access to psychiatric care was a significant reason for the drastic increase in prison suicides, which occurred mostly in the Auckland area.

Against this background, there were a number of well-published cases of homicide and serious violent behaviour by offenders who had psychiatric histories. Public interest is reflected in the large number of inquiries in this area. The Mason Report (1988) stated that between 1971 and 1987 there were 16 inquiries, working parties and investigations, into matters at psychiatric hospitals.

There was also concern about the procedures for obtaining psychiatric reports for defendants, and the Mason committee also reviewed this issue. Judges are required to obtain a preliminary psychiatric assessment prior to remanding defendants for an inpatient psychiatric assessment (s. 121 (2) (b) (ii) CJA, 1985). At the Auckland District Court, this was difficult because staff from Carrington Hospital were unwilling to attend court and reluctant to accept the

recommendations of medical practitioners, other than their own staff. This necessitated a situation when psychiatric issues were queried whereby police transported defendants, to Carrington Hospital and waited during the two to three hour period of the preliminary assessment. This cumbersome and time consuming procedure was contrasted with that at Otahuhu District Court, which is in the catchment of Kingseat hospital, in South Auckland. During 1985 there had been a union nursing ban on patients with security needs. In resolving this dispute Kingseat management negotiated for a senior psychiatric nurse to be employed full-time at the Otahuhu Court, from 1987, as a coordinator of mental health services. This pilot scheme was supported by the judiciary, court, and probation staff, as well as those at Kingseat hospital and met with notable success. It was quickly expanded to include the courts in Papakura and Pukekohe.

The Mason Report (1988) is commendable in resolving the issue of responsibility for the provision of psychiatric services to remandees and offenders. The authors reviewed a number of options and proposed that New Zealand follow the model developed in England. They concluded that:

“It is our firm belief that the responsibility of caring for psychiatrically disturbed people, whether offender or nonoffender, rests exclusively with the health service.”

(Mason Report, 1988 p. 109).

A series of consequent recommendations relating to the establishment of regional forensic psychiatric services were made. The Regional Forensic Psychiatric Services (RFPSs) were to provide medium and minimum secure facilities, liaison services and forensic community services. Within this framework penal institutions and the courts were viewed as part of the community. The National Maximum Secure Unit at Lake Alice was to be retained, at least initially. Emphasis was placed on culturally appropriate service delivery, staff training and the development of forensic psychiatry as a distinct specialty area. The recommendations of the Mason report were largely accepted by Government and finance made available.

The Ministry of Health (1994) reviewed the implementation of the Mason Report recommendations. Regional forensic services had been set up in Auckland, Waikato, Wanganui, Wellington, Christchurch, and Dunedin. This review found that overall; development had focussed mainly on the medium secure inpatient units and it proposed further development in service delivery to the community, particularly to the prison population.

2.1.2 The Court Liaison Service

Part of the new structure that was implemented following the Mason report (1988) was the establishment of the CLS, which was based on the pilot at Kingseat hospital. The CLS is part of the community section of the RFPSs. As part of the service provision to the courts, a psychiatric nurse is made available in major courts to screen defendants for psychiatric difficulties and to make recommendations to the judiciary concerning mental health issues.

By 1992, twelve courts in the Auckland and Northland region had a CLN, with six full-time staff employed. Wade (1992) described the improved situation in Auckland and reported that the general model of the CLS had been adopted nationally. He noted that the CLS dealt exclusively with people who have a major mental illness. Those who did not meet this criterion, such as defendants with substance abuse or personality difficulties, were referred elsewhere. While no data was provided, results of a survey reported by Wade (1992) found that Auckland District Court Judges regarded the CLS to be a 'valuable adjunct' to legal proceedings.

By the time of the Ministry of Health (1994) review, the RFPSs had established CLSs throughout New Zealand and the main District Courts all had CLNs available. Availability to smaller provincial courts was, however, variable. In keeping with an agreement between Justice and Health authorities, Health provided the staff for the CLS and Justice provided interviewing and administrative facilities. This review concluded that CLSs had had a significant impact on the nature of remandees in psychiatric hospitals. Brinded (1991) had estimated that prior to the establishment of the CLS, approximately 60% of inpatient remands had no DSM-III-R Axis I diagnosis on return to the court. Many remands for psychiatric evaluation were therefore inappropriate. With the development of the CLS, court referrals had become more focussed on

those with current or suspected major psychiatric illnesses. The Ministry of Health (1994) review noted that access to mental health services by the courts had become more readily available, with improved outcome for the individuals involved.

Some initial data with regards to the nature and characteristics of those seen by the CLS in Christchurch were provided by Roberts (1992), who reviewed the first year of its functioning, 1991. Roberts met with police, judiciary, and court staff, prison staff, and mental health professionals, and noted that informal feedback from all of these groups was positive. Roberts (1992) concluded that the CLS played an important role, in terms of the efficient coordination of various services, when a mentally ill offender appeared before the courts. During 1991 there were 171 referrals to the CLS and 935 court appearances of clients known to have psychiatric problems. A total of 13 defendants were hospitalised as a consequence of legal proceedings. This represented 7.6% of referrals.

More recently Brinded, Malcolm, Fairley, and Doyle (1996) reported on a review of the Wellington CLS for the year 1993, and Peters and Wade (1996) studied the Auckland CLS for a two year period. While the years of this project are unstated, it is likely to have been between 1993 and 1995. Roberts (1996) reviewed aspects of the Christchurch CLS for a five year period. All of these studies provide descriptive information only, and are used to compare the results of the current study in the discussion (chapter 5.1).

In Christchurch the CLN is an employee of Healthlink South and her position is part of the Christchurch RFPS. She attends daily communication meetings with this team, at Sunnyside hospital, where the opportunity is given to discuss defendants who might possibly warrant referral, and to follow the progress of defendants in the process of assessment. The CLN liaises extensively within the hospital, and with other agencies, so that there is smooth passage for defendants through their legal proceedings.

The CLN is also part of the culture of the court, and is well known amongst the professionals that work there. During legal proceedings in the District Court, she sits beside the duty probation officer and her role is clearly identified by a sign on her desk. Her position is

alongside the judge and legal counsel who face each other and is opposite to defendants as they enter the dock. Various people at court such as legal counsel and the police refer defendants whom they have concerns about. Sometimes formal referrals are completed, but most often a verbal request for assessment is made. The CLN may be called aside before court starts, or during proceedings, or a note is passed across the courtroom. All defendants are seen regardless of whether referral is appropriate, and sometimes even though a psychiatric report is not called for, concerns about the defendant are adequately addressed through the CLS screening, and feedback is given to the referral agency. The CLS also provides an educative role with regards signs and symptoms of psychiatric disorder that may necessitate the calling of a report, and so the CLN acts as a resource person with regards mental health issues generally.

Referred defendants are interviewed as soon as possible, most usually within a few hours of their court appearance. They are seen either in the court cells or in one of the interview rooms available at court. Relevant background information is collected and a semi-structured interview is administered (Appendix 1). A mental status examination, which involves both questions and observations, is completed. On the basis of this screening assessment, a handwritten summary is given to the judge or is submitted verbally during legal proceedings. If there are no indications of psychiatric features, this is outlined, and often a suggestion for intervention is made such as attendance at an alcohol and drug treatment programme. In cases where there are indicators that the defendant may have a psychiatric disorder, a report is recommended. This is very seldom declined. Usually the judge follows the recommendation, and the defendant is remanded for psychiatric evaluation.

The authorisation of the remand of defendants for psychiatric evaluation and report, is provided for in section 121 of the CJA, 1985. Section 121 (1) CJA, 1985 outlines the power of the court to require a psychiatric report if it would assist the court in determining:

“if the defendant is under disability; or if the defendant is insane within the meaning of section 23 of the Crimes Act 1961; or the type and length of any sentence that it might impose; or the nature of any requirement that it may impose as part of, or as a condition of any sentence or order.”

(s. 121 (1) CJA, 1985)

This power can be enacted at any stage during legal proceedings, including following conviction and before sentencing. The defendant must be charged with, or convicted of, an offence punishable by imprisonment, thus excluding minor and non-serious offending.

The summary given to the judge also usually includes a recommendation with regards to the place of the assessment. Defendants can be given bail with a condition that they attend assessment on an outpatient basis (s. 121 (2) (a) CJA, 1985). The time and place is specified before the defendant leaves court and is usually at the community section of the RFPS. Defendants can also be remanded to a penal institution, for psychiatric assessment (s. 121 (2) (b) (i) CJA, 1985) or to a psychiatric hospital (s. 121 (2) (b) (ii) CJA, 1985). Orders pursuant to section 121 (2) (b) (ii) CJA, 1985 require the authorisation of a psychiatrist, who is paged to attend court and again screens the defendant. The period of assessment is limited to two weeks; however, there is a possibility of extension of this time for a further two weeks, with the consent of the defendant. The total period of time of detention under these orders is limited to a month (s. 121 (5) CJA, 1985). If necessary, a defendant's remand to psychiatric hospital is continued pending the hearing or trial (s. 121 (11) CJA, 1985).

The psychiatrist interviews the defendant and on occasions, significant others. At times, he or she is accompanied by staff from other disciplines. Maori health workers are often involved when the defendant is Maori or there are cultural issues involved in the presentation. The psychiatrist reads the police summary of facts, which is made available from court and any information on hospital files, consults with staff from the RFPS multidisciplinary team who have

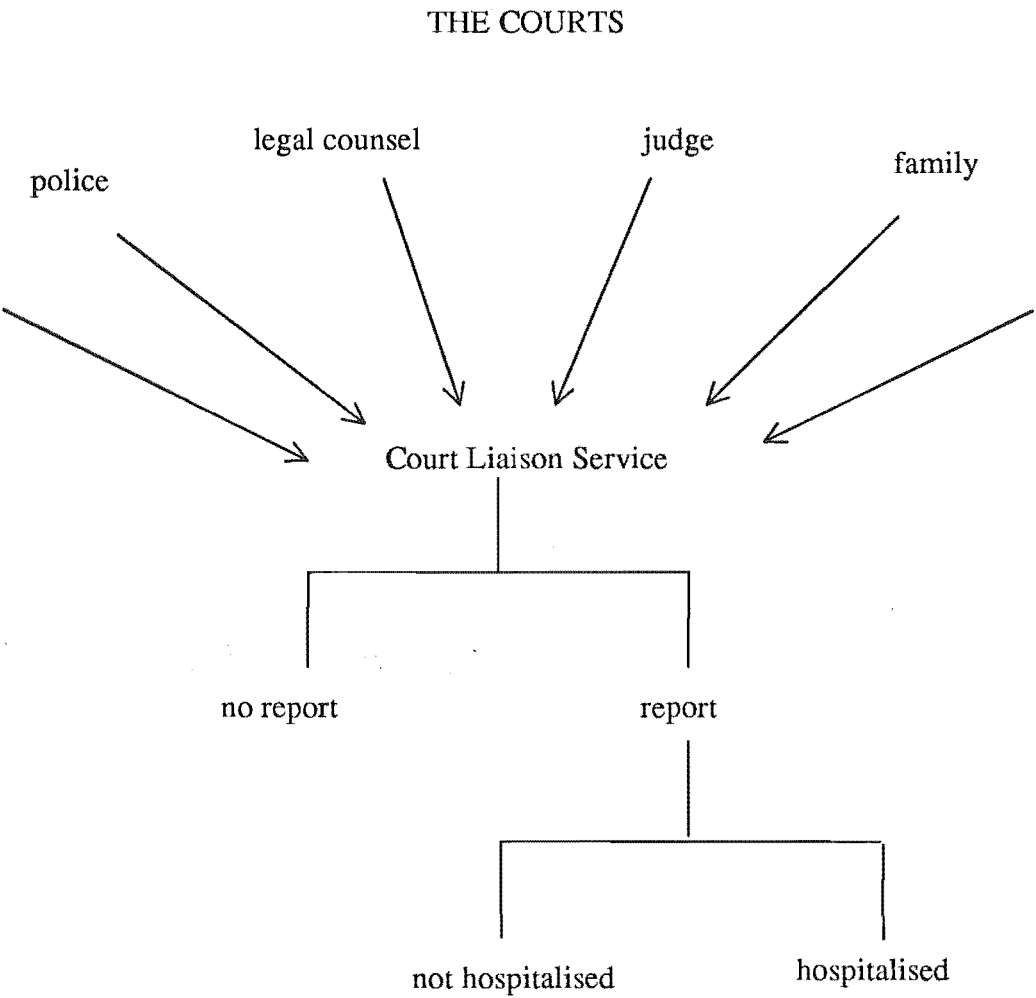
had the opportunity to observe or interview the defendant, and completes any other assessment procedure as indicated. A report is then compiled for the court. In some cases a clinical psychologist also assesses the defendant and independently reports to the court.

The report to the court comments on whether the defendant is insane or under disability and the suitability of psychiatric hospitalisation is considered. Options for disposal might be outlined. The final decision with regards the outcome of the legal proceedings is made by the courts. A judge usually decides the matter, but at times, a jury is involved in determining issues, such as whether the defendant was not guilty by reason of insanity. Most often the findings and recommendations made by mental health professionals as they concern insanity and disability, are accepted by the courts, however, recommendations for section 118 CJA, 1985 hospital orders appear to be more often disputed. A psychiatrically unwell defendant can be excused court appearance at this stage. A medical certificate is required and excuse is dependant on the person's mental state, whether they have legal representation, and whether the person him or her self wants to attend proceedings, or counsel desires to have the person present. Copies of the reports must be disclosed to defendants and defendants' counsel, unless it is regarded that this would endanger the health or safety of any individual (s. 122 CJA, 1985).

Figure 2 summarises and shows diagrammatically the process for defendants that are associated with referral to the CLS, and the decision points that are associated with psychiatric hospitalisation.

Figure 2

Court Liaison Service referrral



2.2 RATIONALE AND AIMS

The CLS is the main 'gateway' for defendants facing criminal charges in New Zealand, to enter the mental health system and to eventually receive psychiatric hospitalisation as an outcome of their court appearance. It is thus pivotal in understanding the interface between the criminal justice and the mental health systems. In the current study the Christchurch CLS was studied as a sample of all New Zealand CLSs, and was regarded as representative.

Little is known about the nature of defendants who are referred to the CLS and their demographic, criminal, and clinical features. The ways in which defendants who receive a psychiatric report are similar or different, from those who do not, remains unknown. Likewise the ways in which defendants who are hospitalised differ from, or are similar to, those who receive a report, but are convicted in the usual manner are also unknown.

Because the legal criteria which allow for entry to the mental health system from the courts tend to be open textured and without operationalisation they are difficult to directly validate. A construct validation approach is useful and generates the questions posed by this study. Comparisons between defendants who receive a psychiatric report and those who do not and between those who are hospitalised and those who are not assist our understanding of the constructs underlying these decision points. By identifying the correlates of decision making of this nature it is possible to examine the understanding of decision-makers of the underlying concepts and to compare these with the relevant legal standards.

The questions posed are also important to investigate the possibility that there may be some systematic biases in decision making. It is possible that demographic, social or crime related factors may be influential in deciding whether a criminal defendant receives a psychiatric report and whether he or she is psychiatrically hospitalised. Theoretically the demographic, social and crime related characteristics of those who receive psychiatric evaluation and report should be similar to the prison population unless these factors are related to the incidence of mental disorder. The specific legal provisions provide for entry to the mental health system to

be based solely on clinical criteria, however the international literature suggests that factors other than clinical ones are sometimes related to decision making in this area.

The current study aims to fill these gaps, and to investigate the following areas:

- (1) Referral information Who, within the court, refers defendants to the CLS and thus makes the decision that psychiatric screening is warranted? What are the reasons given for these referrals? Have defendants been seen previously by the CLS or the RFPS?
- (2) Demographic information What is the gender, ethnicity, and age of defendants? What is their relationship status and living arrangement at the time of the court appearance? Are they employed?
- (3) Crime information Have defendants been convicted before? What is the nature of the index offence for which they face charges?
- (4) Victim information When the crimes involved have direct victims, are they male or female? Did the offending occur between people who knew each other, or between strangers?
- (5) Family information Does the defendant have family support, and to what extent is conflict an aspect of their family background?
- (6) Psychiatric history Have defendants received mental health treatment in the past?
- (7) Alcohol and drugs Do defendants have difficulties with alcohol and drug use? What types of substances are involved? Were they under the influence of alcohol and or drugs at the time of the alleged offending?
- (8) Suicide Do defendants report a history of suicide attempts, and how high is their risk of committing suicide judged to be?
- (9) Mental status What are the results of the mental status examination?
- (10) Diagnoses When diagnoses are made, what are they?

The specific aims of the current study are therefore:

- (1) To describe the characteristics of the total sample of all defendants referred to the CLS.
- (2) To compare referral information, demographic information, crime information, victim information, family information, psychiatric history, alcohol and drug abuse, suicide

history and risk, and mental status information, between the group who receive a psychiatric report and the group who do not.

- (3) To compare referral information, demographic information, crime information, victim information, family information, psychiatric history, alcohol and drug usage, suicide history and risk, and mental status information, between the group who were eventually hospitalised as an outcome of court proceedings, and the group who were assessed but convicted in the usual manner
- (4) To investigate the extent to which it is possible to predict who will receive a psychiatric report, on the basis of the above characteristics? What are the strongest predictor variables of a psychiatric report being prepared and how do they interact with other variables?
- (5) To investigate the extent to which it is possible to predict who receives psychiatric hospitalisation as an outcome of their court proceedings? What are the strongest predictor variables and how do they interact with other predictors?
- (6) To investigate the importance of the presence of psychosis, in determining whom will be hospitalised.

2.3 METHOD

2.3.1 Dependent variables

The files of all defendants seen by the CLN, and for whom a psychiatric screening had been completed between 1992 and 1994, were reviewed. Information relevant to 37 variables (Table 1) was extracted for each assessment. All files contained the form 'Court Liaison Assessment Sheet' (Appendix 1) which had been completed at the time of the assessment by the CLN. It represents a semi-structured interview with general prompts. The 'Court Liaison Record of Outcome' (Appendix 2) was completed also by the CLN when the outcome of the court proceedings was known. Over the time period of this study one specialist psychiatric nurse completed most of the screening assessments. This was not exclusive however and during periods of her absence for reasons such as sickness or vacation, other nurses from the forensic team completed the screenings. When other nurses fulfilled this role they completed the same forms (Appendix 1 and 2) from which information was extracted for this study.

The summary of facts compiled by the Police, for presenting the known circumstances of an alleged crime in court was also available on some files and was consulted. Information regarding psychiatric diagnosis was extracted from the full psychiatric assessment reports (s. 121 CJA, 1985), which were prepared when there was concern about the relevance of psychiatric factors in defendant's criminal offending.

Most information was available in narrative form (Appendix 1 and 2). The first 25 cases were used to establish the categories for coding and these were tested and refined on the next 25 cases. The criterion and decision rules for determining categorisation for the dependent variables is detailed in Appendix 3. Data was coded directly from the files on to Statview (Abacus Concepts, 1987). Because of difficulties in determining relevant groupings and categories for the variables of crime type, family support, family disruption, gender and type of victim, information with regards these variables was copied verbatim as it was available in the files. Categories were established at the completion of data collection and later coded.

The variables were divided into three types: people, assessment, and transaction, as shown in Table 1.

Table 1

Variable types

People variables	Assessment variables	Transaction variables
gender	year	report recommended
age	previous contact	court ordered report
ethnicity	referral agency	outcome
relationship status	referral reason	
accommodation	crime type	
employment status	victim's gender	
criminal history	victim type	
family support	alcohol and/or drugs at the time	
family disruption	suicide risk	
psychiatric history	behaviour	
alcohol and/or drug history	appearance	
alcohol and/or drug type	engagement	
suicide history	mood	
diagnosis	thought form	
	thought content	
	perception	
	orientation	
	memory	
	insight	

This division was made because a number of people appeared on more than one occasion, and artificial inflation would have resulted from more than one entry for information, such as age or gender, for each. Unchanging, or relatively unchanging, data such as history were grouped as people variables. Thus for people variables, the total number refers to the total

number of people seen, regardless of the number of times that each person was assessed. For assessment variables, data pertinent to each separate assessment occasion was collected and analysed. Factors such as reason for referral, crime type, and presentation, change from one assessment occasion to the next. For assessment variables, the total number was the total number of assessments completed regardless of the number of people involved. On some occasions there was one outcome only as a consequence of more than one appearance in court. Thus a person could face further charges, while an initial matter was unresolved and receive one outcome for all charges. Information of this nature was grouped as transaction variables. The number of transactions refers to the number of times the court completed its proceedings with defendants and there was a clear outcome.

2.3.2 Independent variables

The categories used in the description of the variable 'report outcome' were collapsed to form a dichotomous independent variable. The categories used were 'report' or 'no report.' Those defendants who had a psychiatric report completed for the court, whether it was on an outpatient basis, in a penal institution, or in a psychiatric hospital, were classified in the report group. Those who did not have a report completed, were classified into the no report group. This independent variable was used in the results chapters 3.2 and 3.4.

In a similar manner the variable 'outcome', was classified into 'psychiatric group' and 'justice group'. The psychiatric group were those whose eventual outcome of their court appearance was psychiatric hospitalisation. The psychiatric group included those defendants found to be not guilty by reason of insanity, those found to be under disability, those who were found guilty and mentally disordered and a section 118 CJA, hospital order was made, and those for whom the charges were dropped and a compulsory treatment order made, pursuant to the MHA, 1992. Included in the justice group were those who received a prison or community based sentence, and those who received diversion. Also included in the justice group, were those who had charges withdrawn, as an apparent consequence of some form of psychological or psychiatric intervention in the community. While this group is labelled the justice group it refers

to outcomes other than psychiatric hospitalisation. Excluded from this stage of the analysis were cases where the eventual outcome was unknown, those who were transferred outside of the Christchurch area, those who had charges withdrawn for other unknown reasons, and the few cases where the defendant agreed to voluntary hospital admission, was acquitted or committed suicide. A small number of cases were also excluded because there was insufficient complete data. This independent variable was used in the results chapters 3.3 and 3.5.

The reliability of the coding of these variables was determined by comparing the codings independently made by two clinical psychologists. Appendix 4 describes the results of this aspect of the study.

2.3.3 Study design

In the results chapter, the overall sample is initially described (chapter 3.1). In chapter 3.2 a comparison is made between the group of defendants who had a psychiatric report completed and those that did not. In these analyses chi squared and t tests were calculated using Statview (Abacus Concepts, 1987). Post hoc analysis of cell contributions were also made and significant results have been labelled with an asterisk (*). In chapter 3.3 a comparison is made in a similar manner, between the group whose eventual outcome was psychiatric hospitalisation, and the group who received a psychiatric report, but whose outcome was not psychiatric hospitalisation. This latter group is referred to in this study as the justice group, as defined in the manner described above. Cases where the information about a particular variable was unknown have been excluded from the analyses pertaining to that variable.

In chapter 3.4 the results of a discriminant function analysis are described, which examined the ability of the independent variables to predict the completion of a psychiatric report. In chapter 3.5 discriminant function analyses are reported, which predicted subsequent psychiatric admission to hospital. The contribution of the independent variable, diagnosis, in making this prediction is also considered.

2.3.4 Discriminant function analyses

In this stage of the study categorical data were recoded and entered into Statistica (Statsoft, 1994) using an ordinal scale, which enabled discriminant function analyses to be completed. Data were coded 1 when there was no evidence of difficulty in the relevant area and 2 when there was any evidence. For example, for the variable criminal history, no history was coded 1, and if there were any previous convictions a coding of 2 was given. In coding the variable perception, satisfactory perception was rated 1, and any suggestions of hallucinations were coded 2. For the variable gender, females were coded 1 and males 2. The re-coding of the variable diagnoses and the reliability of these ratings is described in Appendix 5. Primary diagnosis only was recorded. In these analyses, in cases where a defendant had been seen on more than one occasion, information relating to the most recent occasion only was used.

Forward, stepwise, discriminant function analyses were conducted. Missing data were substituted with the group means and a priori classification probabilities, proportional to group size were made. Minimum probability to enter (F) was set at 5 in order to reduce the impact of variables that made minimal contribution in the predictions.

In the sections of the results that report the outcome of discriminant function analyses the cononical correlations were calculated using the formula $R^2 = \frac{\lambda_j}{(1 + \lambda_j)}$ to yield the proportion of between group variance. In the tables that describe the results, r shows the correlations between variables. This was calculated using Pearson's product moment method. The proportion of variance shared with the criterion is shown by r^2 and the independent contribution to variance was calculated as 1 minus the partial Wilks lambda. Results which were significant at the $p < .01$ level are identified using a double asterisk (**) and those that were significant at the $p < .05$ level using a single asterisk (*). Relative improvement over chance (RIOC) was calculated using the formula provided by Loeber and Stouthamer-Loeber (1987).

CHAPTER THREE

RESULTS

3.1 SAMPLE DESCRIPTION

In this section, the total sample of all defendants referred to the CLS in Christchurch during 1992 to 1994 is described. A total of 572 screening assessments were completed on 522 people. These resulted in 566 transactions.

3.1.1 Referral information

Of the total sample, 29.7% (170) of the assessments by the CLN were completed during 1992, 36.7% (210) during 1993, and 33.6% (192) during 1994. Of all assessments completed at court, 20.7% (111) involved a defendant who had had previous contact with the RFPS. Referral agencies and the reasons for referral are presented in Table 2. Police, counsel, and duty solicitors made most referrals. Smaller numbers of referrals came from the judge, probation and prison officers, Sunnyside staff, and family members. The defendant having a psychiatric history and concerns about his or her mental state, were the most frequent reasons for referral. Other reasons included the nature of the charge, such as an unusual armed defender callout, the defendant's presentation, and the issue of dangerousness. The possibilities of the defendant being psychiatrically unwell or unfit to plead were also reasons given for referral.

Table 2

Referral information

Variables	Categories	%	N
Referral agency	duty solicitors	18.7	100
	counsel	21.6	116
	police	36.7	197
	probation	6.2	33
	judge	6.7	36
	Sunnyside	4.7	25
	family	2.4	13
	other	3.0	16
Reason for referral	history	19.7	98
	mental state	19.1	95
	nature of the charge	16.5	82
	presentation	12.5	62
	dangerousness	11.3	56
	psychiatrically unwell	8.8	44
	fitness to plead	6.8	34
	recidivist	2.2	11
	other	3.0	15

3.1.2 Demographic information

In the total sample of 522 people, 87.2% (455) were male, and 12.8% (67) were female.

Table 3 shows the age of the sample. The mean age was 30.3 years.

Table 3

Age

	Males	Females	Total
Mean	30.6	28.9	30.3
Standard deviation	10.6	9.9	10.5
Range	14-77	15-56	14-77

In 96.9% of cases, ethnicity was recorded, and this information is presented in Table 4.

Overall 81.4% were Pakeha, 16.7% were of Maori descent, and 1.9% were of Pacific Island origin.

Table 4

Ethnic background

	Males		Females		Total	
	%	N	%	N	%	N
Pakeha	81.7	361	79.6	5.1	81.4	412
Maori	16.5	73	17.2	11	16.7	84
Pacific Islander	1.8	8	0.3	2	1.9	10

Information describing relationship status, accommodation, and employment status, is summarised in Table 5. Most defendants in the sample were single or separated, with smaller percentages living in a married or de facto relationship. In the sample, most lived with their family of origin, or had established and were living in families of their own. Flatting or sharing with friends, was the accommodation for 21.1%, boarding 11.4%, and 13.2% were recorded as having no fixed abode or were living in camping grounds. As shown in Table 5, only 17.4% were in employment and 41.5% were unemployed. Almost a third were on sickness or illness related benefits and the remainder were students, homemakers, or retired.

Table 5

Demographic information

Variables	Categories	%	N
Relationship status	single	68.7	349
	separated	17.5	89
	married	8.7	44
	de facto	5.1	26
Accommodation	own family	20.6	83
	family of origin	28.1	113
	flatting	21.1	85
	boarding	11.4	46
	institution	5.4	22
	no fixed abode	13.2	53
Employment status	employed	17.4	86
	unemployed	41.5	205
	sick	29.4	145
	other	11.7	58

3.1.3 Crime information

In the sample 81.3% (391) had a known history of past criminal offending. The types of crime for which defendants faced charges are presented in Table 6. Most faced charges relating to violence or property offending. Smaller numbers of defendants were charged with sexual crimes, those involving weapons, driving offences, and crimes against the State.

Table 6

Crime type

	%	N
Violence	38.7	221
Property	35.4	202
Sexual	7.2	41
Crimes involving weapons	6.5	37
Driving	4.2	24
Against the state	3.8	22
Drug	1.8	10
Other	2.5	14

3.1.4 Victim information

In 39.2% (224) of cases, a victim was identified. Of these 68.8% (154) were female, and 72.3% (162) of the alleged crimes were domestically related.

3.1.5 Family information

In the CL files, 11.1% (58) of defendants were noted as having family support. There was evidence of family disruption or conflict in 60.7% (317) of the sample.

3.1.6 Psychiatric history

Of all defendants seen at court, 70.2% (339) had had previous contact with mental health services. Psychiatric history is detailed in Table 7. In the sample, 44.7% had previous inpatient admission to a psychiatric hospital. Of these people, 15.7% were being followed up by mental health services at the time of the court appearance. Twenty five percent of people seen at court had no reported history of contact with mental health services. In 4.8% of cases there were suggestions of past mental health difficulties.

Table 7

Psychiatric history (total sample)

	%	N
Inpatient – current follow up	15.7	76
Inpatient – previous	29.0	140
Outpatient – current followup	4.8	23
Outpatient – previous	3.9	19
Counselling	6.6	32
Emergency contact	4.8	23
Previous report	5.4	26
Suggestions	4.8	23
No known past history	25.1	121

3.1.7 Alcohol and drugs

Information relating to alcohol and/or drug usage is shown in Table 8. In the sample 51.0% had a history of alcohol and/or drug related difficulties. Of all cases, 20.7% had had treatment for alcohol and/or drug related difficulties, and 30.4%, while acknowledging difficulties of this nature, had not had treatment. Of those with known alcohol and/or drug related difficulties, or indications of such, 41.2% used a variety of substances, 42.8% used alcohol alone, and smaller numbers reported using marijuana, narcotics, solvents, or abused prescription medication. Of the total sample, 14.5% (83) were clearly under the influence of alcohol and/or drugs at the time of the crime, and a further 14.4% (82) were rated as likely to have been so.

Table 8

Alcohol and/or drug usage

Variables	Categories	%	N
Alcohol and/or drug history	difficulties – treatment	20.7	100
	difficulties – no treatment noted	30.4	147
	noteworthy	15.9	77
	no	33.1	160
Alcohol and/or drug type	polysubstances	41.2	126
	alcohol	42.8	131
	marijuana	4.6	14
	narcotics	5.9	18
	solvents	3.3	10
	prescription medication	2.3	7

3.1.8 Suicide

Of the 80.9% (463) of the sample, where information about suicide was recorded, 16.2% (75) had a history of prior suicide attempts. At the time of the assessment, 52.9% (245) were regarded as being of low suicide risk, 36.0% (167) of moderate risk, and 11.2% (52) of high suicide risk.

3.1.9 Mental status

A summary of the mental status information is shown in Table 9. The behaviour of 40.5% of the sample was rated as being appropriate to the situation. Observations of dysphoric behaviour occurred in 16.1% of the cases, and the behaviour of 10.6% was regarded as agitated. Appropriate appearance was described in 64.8%, and notably untidy appearance in 15.7% of cases. Engagement in the assessment process was reported to be difficult in 18.7% and the defendant uncooperative in 3.7% of the screening assessments. When mood was rated, 29.4% were depressed, 17.2% angry or irritable, 9.2% anxious and 8.4% elevated. Observations of constrained thought form were made in 16.1% of the assessments, and unusual thought content in 32.1% of all assessments. In 10.8% of the assessments, reports of noteworthy perceptual experiences or hallucinations were recorded. Difficulties in orientation were noted in 5.3% of assessments, and the possibility of memory difficulties raised in 24.7%. Three quarters of the sample were reported to have poor or moderate insight.

Table 9

Mental status (total sample)

Variables	Categories	%	N
Behaviour	appropriate	40.5	219
	dysphoric	16.1	87
	agitated	10.6	57
	anxious	8.7	47
	angry	6.6	36
	perplexed	5.2	28
	noteworthy	12.0	65
Appearance	appropriate	64.8	351
	dishevelled	15.7	85
	disability	4.6	25
	weight	3.5	19
	intoxicated	3.5	19
	ill	2.6	14
	noteworthy	5.4	29
Engagement	satisfactory	77.6	420
	difficult	18.7	101
	uncooperative	3.7	20
Mood	appropriate	35.8	191
	depressed	29.4	157
	angry	17.2	92
	anxious	9.2	49
	elevated	8.4	45

Table 9

Mental status (total sample) (cont.)

Variables	Categories	%	N
Thought form	satisfactory	71.4	385
	constrained	16.1	87
	pressurised	5.8	31
	noteworthy	6.7	36
Thought content	satisfactory	67.9	359
	delusional	11.3	60
	stressors	13.0	69
	noteworthy	7.8	41
Perception	satisfactory	89.1	468
	hallucinations	3.4	18
	noteworthy	7.4	39
Orientation	satisfactory	94.7	521
	difficulties	5.3	29
Memory	satisfactory	75.3	344
	noteworthy	24.7	113
Insight	satisfactory	25.0	114
	poor	64.0	292
	moderate	11.0	50

3.1.10 Outcome of the court proceedings

Of all transactions, 14.3% (81) resulted in a recommendation of remand for inpatient assessment. Further psychiatric assessment was recommended on an outpatient basis for 13.8% (78), and in prison 8.3% (47). For an additional 5.8% (33), a recommendation was made for further psychiatric assessment without specification of its location. In total 42.2% (239) of all transactions, resulted in a recommendation for further psychiatric assessment and report.

The court ordered further psychiatric assessment and reports to the court in 42.7% (242), of all transactions. Of these, 38.8% (94) were completed on an inpatient basis, 36.8% (89) on an outpatient basis, and 24.4% (59) in prison.

Of all transactions, the final outcome of the court proceedings was known in 99.1% (561) of cases. Final outcome is shown in Table 10. Of these, 2.0% were found to be insane at the time of the crime, and 0.7% were under a disability and unfit to plead. Orders under section 118 CJA, 1985, were made in 2.9% of transactions. Charges were withdrawn in 5.9% of cases and a compulsory treatment order was made. In 6.4% of transactions, charges were withdrawn and the defendant agreed to a community based psychiatric or psychological intervention. Prison sentences were received by 25.1% of defendants and 43.1% received a community based sentence. Three people were acquitted and two people committed suicide.

Table 10

Outcome of the court proceedings

	%	N
Insanity	2.0	11
Disability	0.7	4
S 118 CJA, 1985	2.9	16
Charge withdrawn - compulsory treatment order	5.9	33
Charge withdrawn – voluntary inpatient treatment	0.4	2
Charge withdrawn - community intervention	6.4	36
Charge withdrawn – other	5.2	29
Prison sentence	25.1	141
Community sentence	43.1	242
Diversion	2.3	13
Transfer	5.2	29
Acquitted	0.5	3
Suicide	0.4	2

3.2 COMPARISON OF THE GROUP WHO RECEIVED A PSYCHIATRIC REPORT, WITH THE GROUP WHO DID NOT

In this section a comparison is made between the group who received a psychiatric report (report group) and the group who did not (no report group). Sufficient information was available to enable analyses from the screening assessments of 228 cases that received a report, and 291 cases that did not. This resulted in 219 people who received a report and 280 who did not.

3.2.1 Referral information

There was no significant difference across the years, in the percentage of all those seen by the CLN who received a psychiatric report (1992 48.4% (76), 1993 43.9% (83), 1994 39.9% (69)). ($\chi^2 (2) = 2.4$, n.s.) Significantly more of those for whom a report was completed had been seen previously by RFPS staff (report group 25.0% (57); no report group 15.6% (44). ($\chi^2 (1) = 7.0$, $p < .01$).

There was a significant difference, between the two groups, in terms of their referral agencies ($\chi^2 (7) = 23.8$, $p < .01$), and this is shown in Table 11. Post-hoc analysis of cell contributions shows that the police referred proportionately more of those for whom a psychiatric assessment was ordered by the court. Duty solicitors, the judge, and probation officers made fewer referrals that resulted in a full psychiatric assessment and report.

Table 11

Referral agency

	Report		No report	
	%	N	%	N
Duty solicitors*	14.4	32	22.1	64
Counsel	22.5	50	21.4	62
Police*	44.6	99	30.3	88
Probation*	4.1	9	8.3	24
Judge*	3.6	8	9.0	26
Sunnyside staff	6.3	14	3.5	10
Family	1.3	3	2.8	8
Other	3.1	7	2.1	6

The reasons given for referral were not significantly different between the two groups (report group: history 21.2% (44), mental state 15.9% (33), nature of the charge 20.7% (43), presentation 11.5% (24), dangerousness 10.1% (21), psychiatrically unwell 8.7% (18), fitness to plead 7.7% (16), recidivist 1.4% (3), other 1.4% (6); no report group: history 19.3% (51), mental state 23.1% (61), nature of the charge 14.0% (37), presentation 11.4% (30), dangerousness 12.8% (34), psychiatrically unwell 8.3% (22), fitness to plead 5.7% (15), recidivist 2.7% (7), other 2.7% (7)). (χ^2 (8) = 8.6, n.s.)

3.2.2 Demographic information

There were significantly more males and fewer females in the group for whom a psychiatric report was completed, compared with the group who did not receive a psychiatric report. ($\chi^2 (1) = 4.1, p < .05$) Gender is shown in Table 12. The mean age of the group who received a report was 31.7 years, and 29.3 years for the group who did not. This difference is statistically significant. ($t (496) = 2.5, p < .05$)

Table 12

Gender (report group and no report group)

	Report		No report	
	%	N	%	N
Males	91.3	200	85.4	239
Females	8.7	19	14.6	41

The ethnicity of the two groups was similar (report group: Pakeha 80.2% (170), Maori 16.5% (35), Pacific Islander 3.3% (7); no report group: Pakeha 83.0% (224), Maori 15.9% (43), Pacific Islander 0.1% (3)). ($\chi^2 (2) = 2.9, n.s.$)

Likewise their relationship status was not statistically different (report group: single 66.8% (183), separated 17.1% (47), married 8.4% (23), defacto 7.7% (21); no report group: single 70.4% (152), separated 19.0% (41), married 7.9% (17), defacto 2.8% (6)). ($\chi^2 (3) = 5.7, n.s.$)

The two groups differed in their accommodation. ($\chi^2 (5) = 11.7, p < .05$) Post hoc analysis of cell contributions indicated that this was accounted for by less of those in the group who received a report living with their own families. In the report group 12.2% (22) were recorded as living with their own families, and in the no report group 24.1% (59) were doing so, (report group: family of origin 29.4% (53), flatting 28.3% (51), boarding 10.0% (18), institution

5.0% (9), no fixed abode 15.0% (27); no report group: family of origin 24.1% (59), flatting 27.4% (67), boarding 10.6% (26), institution 4.5% (11), no fixed abode 9.4% (23)).

Employment was not statistically different (report group: employed 13.2% (27), unemployed 44.6% (91), sick 28.4% (58), other 13.7% (28); no report group: employed 21.0% (57), unemployed 39.0% (106), sick 30.2% (82), other 9.9% (27)). ($\chi^2(3) = 6.4$, n.s.)

3.2.3 Crime information

There was no significant difference between the two groups, in whether they had a history of past offending (report group 80.2% (162); no report group 82.1% (216)). ($\chi^2(1) = .28$, n.s.)

The types of crime which members of the two groups were charged with, also did not differ significantly ($\chi^2(7) = 12.0$, n.s.), however, 44.2% (106) of those for whom a psychiatric assessment and report was completed were charged with violent crimes, whereas 33.8% (101) of the group for whom no report was ordered, appeared on charges relating to violent behaviour (report group: property 31.3% (75), sexual 6.7% (16), weapons 8.3% (20), driving 3.8% (9), State 3.3% (8), drugs 0.8% (2), other 1.7% (4); no report group: property 38.1% (114), sexual 7.4% (22), weapons 5.3% (16), driving 4.7% (14), State 4.7% (14), drugs 2.3% (7), other 3.8% (11)).

3.2.4 Victim information

There were no statistically significant differences between these two groups in the proportion of victims that were female (report group 65.8% (75); no report group 71.4% (70) ($\chi^2(1) = .78$, n.s.), and whether the crime was domestically related (report group 61.7% (79); no report group 65.8% (75)). ($\chi^2(1) = .43$, n.s.)

3.2.5 Family information

There were no significant differences between the two groups in their family support (report group: 10.6% (23); no report group 12.5% (35)) ($\chi^2 (1) = .45$, n.s.), and degree of family disruption (report group: 58.3% (127); no report group 64.3% (180)). ($\chi^2 (1) = 1.9$, n.s.)

3.2.6 Psychiatric history

The psychiatric history of the two groups however, was significantly different ($\chi^2 (8) = 36.9$, $p < .01$) and is detailed in Table 13. Post hoc analysis of cell contributions indicated that more of those in the group for whom no report was ordered had no history of psychiatric contact. In the group for whom a report was ordered, proportionately more had histories of inpatient care, and there were more suggestions of previous psychiatric difficulties.

Table 13

Psychiatric history (report group and no report group)

	Report		No report	
	%	N	%	N
Inpatient - current followup*	18.8	39	11.5	30
Inpatient - previous*	35.3	73	24.6	64
Outpatient - current followup*	1.9	4	6.9	18
Outpatient - previous*	3.4	7	4.6	12
Counselling	6.8	14	6.5	17
Emergency contact	5.8	12	4.2	11
Previous report	4.4	9	6.2	16
Suggestions*	7.7	16	2.3	6
No known past history	15.9	33	33.1	86

3.2.7 Alcohol and drugs

When alcohol and/or drug history was compared, there were no significant differences between the two groups (report group: difficulties - treatment 17.9% (36), difficulties - no treatment 28.4% (57), noteworthy 14.4% (29); no report group: difficulties - treatment 23.3% (62), difficulties - no treatment 31.6% (84), noteworthy 16.2% (43)). ($\chi^2 (3) = 5.9$, n.s.) When alcohol and/or drug difficulties were reported, there were no differences in the types of substances that were used (report group: polysubstances 46.5% (53), alcohol 43.0% (49), marijuana 5.3% (6), other 5.3% (6); no report group: polysubstances 39.2% (71), alcohol 44.2% (80), marijuana 4.4% (8), other 12.2% (22)). ($\chi^2 (3) = 4.5$, n.s.) Significantly more of those in the group for whom a report was not ordered, were rated as likely to have been using alcohol and/or drugs, at the time of the alleged crime (report group 10.8% (26); no report group 18.1% (54)). ($\chi^2 (2) = 7.9$, $p < .05$)

3.2.8 Suicide

There was no significant difference in the frequency of history of suicide attempts, between the group who received a report, and the group who did not (report group 18.3% (31); no report group 16.4% (40)). ($\chi^2 (1) = .27$, n.s.) Suicide risk was also rated similarly between the two groups (report group: low 52.7% (97), moderate 36.4% (67), high 10.9% (20); no report group: low 51.9% (136), moderate 36.7% (96), high 11.5% (30)). ($\chi^2 (2) = .05$, n.s.)

3.2.9 Mental status

Mental status information for the two groups is presented in Table 14. There were significant differences between the two groups on all of the mental status variables. Post hoc analysis of cell contributions indicated that there were fewer observations of satisfactory behaviour and more of noteworthy and perplexed behaviour, in the group for whom a psychiatric report was completed. This group was more often dishevelled in appearance, and more observations of noteworthy appearance were made. The group who received a report appeared

to be less often intoxicated. There were more difficulties in engagement in the group for whom a psychiatric report was ordered, and satisfactory engagement was less frequent. In the group who received a report, there were more observations of mood elevation. Thought form was more often pressurised, constrained, or a noteworthy observation was made, and less often satisfactory. Thought content was more often delusional, or noteworthy, and less often concerned with recent stressors, or satisfactory. There were more reports of hallucinatory perceptions, and less of satisfactory perception. The group for whom a report was ordered, also had more orientation difficulties, and less often satisfactory orientation. There were more memory difficulties, and less descriptions of satisfactory memory. Insight was more frequently poor or moderate in the group for whom a report was ordered and less often satisfactory.

Table 14

Mental status (report group and no report group)

Variables	Categories	Report		No report	
		%	N	%	N
Behaviour	appropriate*	31.9	72	48.1	140
	dysphoric	17.7	49	15.8	46
	agitated	10.2	23	10.3	30
	anxious	8.0	18	8.6	25
	angry	7.5	17	6.2	18
	perplexed*	8.8	20	2.4	7
	noteworthy*	15.9	36	8.6	25
$\chi^2 (6) = 26.6, p < .01$					

Table 14

Mental status (report group and no report group) (cont.)

Variables	Categories	Report		No report	
		%	N	%	N
Appearance	appropriate	61.8	141	66.0	192
	dishevelled*	19.7	45	12.7	37
	disability	4.8	11	4.8	14
	weight	2.2	5	4.8	14
	intoxicated*	0.5	1	5.8	17
	ill	2.6	6	2.4	7
	noteworthy*	8.3	19	3.4	10
$\chi^2 (6) = 22.1, p < .01$					
Engagement	satisfactory*	69.3	158	85.2	248
	difficult*	25.9	59	11.7	34
	uncooperative	4.8	11	3.1	9
$\chi^2 (2) = 19.5, p < .01$					
Mood	appropriate	30.6	68	39.0	113
	depressed	30.2	67	30.7	89
	angry	17.1	38	17.3	50
	anxious	9.5	21	8.6	25
	elevated*	12.6	28	4.5	13
$\chi^2 (4) = 13.0, p < .05$					
Thought form	satisfactory*	58.9	133	80.8	235
	constrained*	22.6	51	12.0	35
	pressurised*	8.4	19	3.4	10
	noteworthy*	10.2	23	3.8	11
$\chi^2 (3) = 30.6, p < .01$					

Table 14

Mental status (report group and no report group) (cont.)

Variables	Categories	Report		No report	
		%	N	%	N
Thought content	satisfactory*	55.1	120	78.2	226
	delusional*	24.3	53	1.7	5
	stressors*	9.2	20	15.6	45
	noteworthy*	11.5	25	4.5	13
$\chi^2 (3) = 77.2, p < .01$					
Perception	satisfactory*	80.1	173	96.5	278
	hallucinations*	18.1	39	2.1	6
	noteworthy	1.9	4	1.4	4
$\chi^2 (2) = 39.2, p < .01$					
Orientation	satisfactory*	91.7	209	96.6	281
	difficulties*	8.3	19	3.4	10
$\chi^2 (1) = 5.8, p < .05$					
Memory	satisfactory*	69.1	123	79.2	206
	noteworthy*	30.9	55	20.8	54
$\chi^2 (1) = 5.8, p < .05$					
Insight	satisfactory*	16.1	30	30.8	77
	poor*	73.1	136	11.6	29
	moderate*	10.8	20	57.6	144
$\chi^2 (2) = 13.4, p < .01$					

3.3 COMPARISON OF THE GROUP WHO WERE HOSPITALISED WITH THE GROUP WHO WERE NOT

In this section a comparison is made between two subgroups of all those who had a psychiatric report completed. The group whose eventual outcome of their court appearance was psychiatric hospitalisation (psychiatric group), was compared with the group whose outcome was a correctional sanction (justice group). Sufficient information was available to enable analyses from the screening assessments of 58 cases that were hospitalised, and 166 cases that were not. This resulted in 52 people who were hospitalised, and 152 people who were not.

3.3.1 Referral information

Similar proportions of those who received a psychiatric report were subsequently admitted to a psychiatric hospital over the years of the study (1992 24.1% (14), 1993 43.1% (25), 1994 32.8% (19)). ($\chi^2 (2) = 3.7$, n.s.) Significantly more of the psychiatric group had previous contact with the RFPS (psychiatric group 43.6% (24): justice group 21.2% (33)). ($\chi^2 (1) = 10.4$, $p < .01$)

Referral agents were similar between the two groups (psychiatric group: duty solicitors 15.7% (8), counsel 9.8% (5), police 58.8% (30), probation 2.0% (1), judge 3.9% (2), Sunnyside 7.8% (4), family 2.0% (1), other 0; justice group: duty solicitors 17.0% (26), counsel 24.8% (38), police 38.6% (59), probation 5.2% (8), judge 3.3% (5), Sunnyside 6.5% (10), family 1.3% (2), other 3.3% (6)). ($\chi^2 (7) = 10.6$, n.s.)

The reasons for referral were, however, significantly different between the psychiatric and the justice group. ($\chi^2 (8) = 24.9, p < .01$) This is presented in Table 15. Post hoc analysis of cell contributions indicated that referrals involving concerns about dangerousness accounted for this difference.

Table 15

Referral reasons (psychiatric group and justice group)

	Psychiatric group		Justice group	
	%	N	%	N
History	28.3	13	18.6	27
Mental state	13.0	6	17.2	25
Nature of the charge	10.9	5	22.1	32
Presentation	28.3	13	8.3	12
Dangerousness*	0	0	15.5	22
Psychiatrically unwell	13.0	6	7.6	11
Fitness to plead	6.5	3	6.9	10
Recidivist	0	0	2.1	3
Other	0	0	2.1	3

3.3.2 Demographic information

Gender is shown in Table 16. When these numbers were compared, the results were not statistically significantly different. ($\chi^2 (2) = 3.4, n.s.$)

Table 16

Gender (psychiatric group and justice group)

	Psychiatric group		Justice group	
	%	N	%	N
Males	98.1	51	90.1	137
Females	1.9	1	9.9	15

Age was not significantly different (psychiatric group mean = 33.9 years, justice group mean = 30.8 years). ($t(201) = 1.7$, n.s.). Ethnicity also was not significantly different between the two groups (psychiatric group: Pakeha 81.6% (40), Maori 18.4% (9), Pacific Islander 0; justice group: Pakeha 79.7% (118), Maori 15.5% (23), Pacific Islander 4.7% (7)). ($\chi^2(2) = 2.5$, n.s.) The relationship status of the two groups was similar (psychiatric group: single 71.4% (35) separated 18.4% (9), married 6.1% (3), defacto 4.1% (2); justice group: single 72.0% (108), separated 17.3% (26), married 8.0% (12), defacto 2.7% (4). ($\chi^2(3) = 4.4$, n.s.) Accommodation was not significantly different between the two groups (psychiatric group: own family 8.9% (4), family of origin 22.2% (10), flatting 37.8% (17), boarding 6.7% (3), institution 4.4% (2), no fixed abode 20.0% (9); justice group: own family 20.0% (26), family of origin 29.2% (38), flatting 23.1% (30), boarding 10.8% (14), institution 4.6% (6), no fixed abode 12.3% (16)). ($\chi^2(5) = 7.7$, n.s.)

Employment status was also similar, between the two groups (psychiatric group: employed 4.2% (2), unemployed 41.7% (20), sick 39.6% (19), other 14.6% (7); justice group: employed 14.9% (21), unemployed 46.8% (66), sick 26.9% (38), other 11.4% (16)). ($\chi^2(5) = 5.8$, n.s.)

3.3.3 Crime information

Significantly more of the psychiatric group had a history of past offending (92.3% (36) than did the justice group (77.3% (112)). ($\chi^2(1) = 4.2$, $p < .05$) The types of crime for which defendants faced charges, were similar between the two groups (psychiatric group: violent 48.3% (28), property 29.3% (17), sexual 3.5% (2), weapons 12.1% (7), driving 0, State 1.7% (1), drugs 0, other 5.2% (3); justice group: violent 41.6% (69), property 33.1% (55), sexual 7.2% (12), weapons 7.2% (12), driving 5.4% (9), State 3.6% (6), drugs 1.2% (2), other 0.6% (1)). ($\chi^2(7) = 12.2$, n.s.)

3.3.4 Victim information

In the justice group there were significantly more female victims (psychiatric group 48.2% (14); justice group 69.7% (53)). ($\chi^2 (1) = 4.0, p < .05$) In the justice group, victims were more frequently involved in a domestic relationship with the offender (psychiatric group 43.3% (13); justice group 66.7% (58)). ($\chi^2 (1) = 5.1, p < .05$)

3.3.5 Family information

Family support was similar for the two groups (psychiatric group 13.7% (7); justice group 9.9% (15)). ($\chi^2 (1) = 0.6, n.s.$) There was evidence of significantly more family disruption in the justice group (psychiatric group 43.1% (22); justice group 60.5% (92)) ($\chi^2 (1) = 4.7, p < .05$)

3.3.6 Psychiatric history

The psychiatric history of the two groups was significantly different ($\chi^2 (8) = 35.0$, $p < .01$) and is detailed in Table 17. Post hoc analysis of cell contributions indicated that this was accounted for by proportionately more of the psychiatric group having had a history of inpatient psychiatric admission, and previous outpatient contact. More of the justice group had no known psychiatric history, and more had attended counselling.

Table 17

Psychiatric history (psychiatric group and justice group)

	Psychiatric group		Justice group	
	%	N	%	N
Inpatient - current followup*	36.2	17	14.8	21
Inpatient - previous*	48.9	23	30.3	43
Outpatient - current followup	2.1	1	4.2	6
Outpatient - previous*	6.4	3	0.7	1
Counselling*	0	0	8.5	12
Emergency	0	0	6.3	9
Previous report	2.1	1	5.6	8
Suggestions*	2.1	1	9.2	13
No known past history	2.1	1	20.4	29

3.3.7 Alcohol and drugs

A similar proportion in each group had a history of alcohol and/or drug related difficulties (psychiatric group: difficulties - treatment 23.8% (10), difficulties - no treatment 19.1% (8), noteworthy 19.1% (8); justice group: difficulties - treatment 18.3% (25), difficulties - no treatment 30.7% (42), noteworthy 13.1% (18)) ($\chi^2 (3) = 2.8$, n.s.). There were no differences between the two groups in the types of substances that were used (psychiatric group:

polysubstances 57.7% (15), alcohol 38.5% (10), marijuana 3.9% (1), other 0; justice group: polysubstances 43.2% (35), alcohol 44.4% (36), marijuana 4.9% (4), other 7.4% (6)). ($\chi^2 (3) = 3.0$, n.s.) There were also no significant differences in whether alcohol and/or drugs were used at the time of the crime (psychiatric group: acknowledged 14.3% (2), likely 35.7% (5); justice group: acknowledged 34.5% (20), likely 32.8% (19)). ($\chi^2 (2) = 2.5$, n.s.)

3.3.8 Suicide

Significantly more of the justice group had recorded histories of suicide attempts (psychiatric group 0, justice group 21.5% (26)). ($\chi^2 (1) = 8.8$, $p < .01$). Suicide risk was rated as being low more often in the psychiatric group (psychiatric group 84.6% (33); justice group 43.1% (56)), and in the justice group more often moderate (psychiatric group 12.8% (5); justice group 42.3% (55)), and high (psychiatric group 2.6% (1); justice group 14.6% (19)). ($\chi^2 (2) = 20.9$, $p < .01$)

3.3.9 Mental status

Seven of the ten mental status variables were significantly different between the two groups. Table 21 presents the results of these comparisons. Post hoc analysis of cell contributions indicated that in the justice group there were significantly more people whose behaviour was rated as appropriate, and more whose behaviour was regarded as being dysphoric. The behaviour of more of those in the psychiatric group was described as noteworthy. There were more occasions of satisfactory engagement in the justice group and more of difficult engagement and uncooperativeness, in the psychiatric group. Mood was more frequently appropriate in the psychiatric group. There was evidence of more depressed mood in the justice group, and of more elevated mood in the psychiatric group. Thought form was more frequently satisfactory in the justice group. Observations of constrained thought form and noteworthy features, were more frequent in the psychiatric group. Delusional thought content was significantly more frequent in the psychiatric group and satisfactory thought content was more

frequent in the justice group. Satisfactory perception was more frequent in the justice group. There were more reports of hallucinatory experiences in the psychiatric group, and more of noteworthy perceptual features. Orientation was more often satisfactory in the justice group and there were more often difficulties in the psychiatric group. There were no significant differences between the two groups, on the variables of appearance, memory, and insight.

Table 18

Mental status (psychiatric group and justice group)

Variables	Categories	Psychiatric group		Justice group	
		%	N	%	N
Behaviour	appropriate*	20.4	11	37.0	57
	dysphoric*	7.4	4	19.5	30
	angry	11.1	6	7.1	11
	agitated	9.3	5	11.0	17
	anxious	3.7	2	10.4	16
	perplexed	14.8	8	6.5	10
	noteworthy*	33.3	18	8.4	13
$\chi^2 (6) = 29.7, p < .01.$					
Appearance	appropriate	50.9	27	63.9	99
	dishevelled	32.1	17	15.5	24
	disability	5.7	3	6.5	10
	weight	1.9	1	2.6	4
	intoxicated	0	0	3.9	6
	ill	0	0	1.3	2
	noteworthy	9.4	5	6.5	10
$\chi^2 (6) = 9.9, n.s.$					

Table 18

Mental status (psychiatric group and justice group) (cont.)

Variables	Categories	Psychiatric group		Justice group	
		%	N	%	N
Engagement	satisfactory	42.3	24	76.4	120
	difficult*	43.4	23	21.0	33
	uncooperative*	11.3	6	2.6	4
$\chi^2 (2) = 19.5, p < .01.$					
Mood	appropriate*	42.3	22	27.9	43
	depressed*	11.6	6	35.1	54
	elevated*	30.8	16	7.1	11
	anxious	3.9	2	10.4	16
	angry	11.5	6	19.5	30
$\chi^2 (4) = 29.8, p < .01.$					
Thought form	satisfactory*	36.5	19	68.4	106
	pressurised	13.5	7	7.7	12
	constrained*	30.8	16	16.8	26
	noteworthy*	19.2	10	7.1	11
$\chi^2 (3) = 17.3, p < .01$					
Thought content	satisfactory*	16.0	8	69.5	105
	delusional*	66.0	33	11.3	17
	noteworthy	14.0	7	9.9	15
	stressors	4.0	2	9.3	14
$\chi^2 (3) = 66.3, p < .01.$					
Perception	satisfactory*	53.2	25	88.7	134
	hallucinations*	19.2	9	3.3	5
	noteworthy*	27.7	13	8.0	12
$\chi^2 (2) = 29.4, p < .01.$					

Table 18

Mental status (psychiatric group and justice group) (cont.)

Variables	Categories	Psychiatric group		Justice group	
		%	N	%	N
Orientation	satisfactory*	74.1	43	92.8	154
	difficulties*	25.9	15	7.2	12
$\chi^2 (1) = 14.1, p < .01.$					
Memory	satisfactory	57.9	22	72.8	91
	noteworthy	42.1	16	27.2	34
$\chi^2 (1) = 3.0, n.s.$					
Insight	satisfactory	4.7	2	16.3	21
	poor	4.7	2	10.1	13
	moderate	90.7	39	73.6	95
$\chi^2 (2) = 5.6, n.s.$					

3.3.10 Diagnoses

The diagnoses of the two groups are shown in Table 19. The diagnoses of the psychiatric group were significantly different from those of the justice group. ($\chi^2 (10) = 85.6, p < .01$) Post hoc analysis of cell contributions, in order of magnitude, indicated that schizophrenia was diagnosed more frequently in the psychiatric group. Substance abuse or dependency was more frequent in the justice group. Unspecified psychoses were diagnosed more in the psychiatric group, as were other diagnoses. There were more occasions when no diagnoses were made in the justice group, and depression was more frequently diagnosed in this group. Bipolar affective disorder occurred more frequently in the psychiatric group. Antisocial personality disorder and other personality disorders were diagnosed more frequently in the justice group.

Table 19

Diagnoses

	Psychiatric group		Justice group	
	%	N	%	N
Schizophrenia*	43.8	25	8.8	13
Bipolar affective disorder*	17.5	10	6.8	10
Psychotic (unspecified)*	14.0	8	2.0	3
Depression*	1.8	1	12.2	18
Substance abuse or dependency*	0	0	27.0	40
Antisocial personality disorder*	0	0	6.8	10
Other personality disorders*	0	0	8.1	12
Organic impairment	5.3	3	4.1	6
Intellectual impairment	0	0	3.4	5
Other diagnoses*	14.0	8	4.1	6
None*	3.5	2	16.9	25

3.4 PREDICTION OF PSYCHIATRIC REPORT

In this section the predictive efficiency of variables assessed during the screening by the CLN, to the criterion of the completion of a psychiatric report is examined. Thirteen predictor variables were entered into the analysis. They were age, gender, psychiatric history, and all ten of the mental status variables. These were chosen from the comparative analysis of the two groups (chapter 3.2), as being most likely to have possible predictive power.

The results of this analysis were significant. Wilks' lambda = .67, $F(5, 492) = 47.7$, $p < .01$. The canonical correlation indicated that 32.4% of the variance in predicting completion of a psychiatric report was accounted for. Table 20 shows the five predictor variables and the contributions to variance that they make.

Table 20

Discriminant function analysis of psychiatric report

Predictors	r	r ²	Independent contribution to variance
Psychiatric history	.51**	.26	.23**
Perception	.26**	.07	.02**
Age	.13**	.02	.02**
Thought form	.21**	.04	.02**
Thought content	.22**	.05	.02**

Table 21 presents the intercorrelations amongst the predictor variables. The presence of a psychiatric history, correlated significantly with disturbances in the areas of perception, thought form and thought content. Age was associated with difficulties in thought content. The mental status variables of perception, thought form, and thought content, were significantly intercorrelated.

Table 21

Correlations amongst variables used to predict psychiatric report

	Age	Perception	Thought form	Thought content
Psychiatric history	-.05	.14**	.11*	.09*
Age		.04	.09	.10*
Perception			.16**	.29**
Thought form				.09*

Psychiatric history N = 477, Age N = 498, Perception N = 475, Thought form N = 484, Thought content N = 476.

The analysis produced accurate classifications in 74.1% of cases, including 71.6% of the group who received a psychiatric report and 75.9% of those that did not. Table 22 presents the number of cases in each cell of the classification matrix. RIOC was 76.1%.

Table 22

Classification matrix (psychiatric report)

		Outcome	
		Report	No report
Prediction	Report	149 (true positives)	59 (false positives)
	No report	70 (false negatives)	220 (true negatives)

3.5 PREDICTION OF HOSPITALISATION

In this section the ability of the independent variables to predict the criterion of psychiatric hospitalisation, compared with no hospitalisation is examined, using discriminant function analyses. The group who received a psychiatric report was used for these analyses. The contribution of diagnosis was explored.

3.5.1 Discriminant function analysis of hospitalisation, excluding diagnosis

Ten variables were entered into this analysis. These were criminal history, psychiatric history, suicide risk and the mental status variables of behaviour, engagement, mood, thought form, thought content, perception, and orientation. The results of this analysis, using five predictor variables were significant. Wilks' lambda = .66, $F(5, 197) = 19.9$, $p < .01$. The canonical correlation indicated that the model produced by this analysis, accounted for 33.3% of the between group variance. Table 23 shows the contribution to variance that was made by each predictor variable.

Table 23

Discriminant function analysis of hospitalisation, excluding diagnosis

Predictors	r	r ²	Independent contributions to variance
Thought content	.47**	.22	.14**
Perception	.37**	.14	.06**
Mood	-.16	.03	.05**
Psychiatric history	.19**	.04	.05**
Thought form	.24**	.06	.03**

Table 24 presents the correlations amongst the predictor variables. Diagnosis was also included in this table and is considered below. Disturbances in thought content were significantly associated with disturbances in thought form and perception. The correlation between thought form and perception was not significant. Mood and psychiatric history did not correlate significantly with the mental status variables.

Table 24

Correlations amongst variables used to predict hospitalisation

	Thought form	Perception	Mood	Psychiatric history	Psychiatric diagnosis
Thought content	.21**	.35**	.07	.02	.37**
Thought form		.11	.05	-.06	.19**
Perception			.02	.01	.27**
Mood				-.03	-.10
Psychiatric history					.27**

Thought content N = 190, Thought form N = 194, Perception N = 188, Mood N = 192, Psychiatric history N = 194, Diagnosis N = 203.

The analysis produced 82.8% accurate classification of cases. There were 59.6% accurate classifications made of those who were hospitalised, and 90.7% accurate classifications of those who were not. The classification matrix is shown in Table 25. RIOC was 86.9%.

Table 25
Classification matrix (hospitalisation, excluding diagnoses)

		Outcome	
		Hospitalised	Not hospitalised
Prediction	Hospitalised	31 (true positives)	14 (false positives)
	Not hospitalised	21 (false negatives)	137 (true negatives)

3.5.2 Discriminant function analysis of hospitalisation, including diagnosis

The discriminant function analysis described in section 3.5.1 was repeated with diagnosis included as a predictor variable. This analysis yielded significant results. Wilks' lambda = .55, $F(4, 198) = 40.6$, $p < .01$. The canonical correlation indicated that 45.1% of the between group variance had been accounted for. Table 26 shows the predictor variables in this model and the contribution that they make to variance.

Table 26

Discriminant function analysis of hospitalisation, including diagnosis

Predictors	r	r ²	Independent contributions to variance
Diagnosis	.59**	.35	.23**
Thought content	.47**	.22	.08**
Perception	.37**	.14	.03**
Mood	-.16	.03	.03*

Table 24 above, shows that diagnosis was significantly correlated with difficulties in thought form, thought content, perception and with psychiatric history.

The model produced from this analysis was able to correctly classify 85.7% of all cases. There was correct identification of 71.2% of those who were hospitalised, and 90.7% of those who were not. Table 27 shows the numbers in the classification matrix. R.I.O.C.was 90.4%.

Table 27

Classification matrix (hospitalisation, including diagnoses)

		Outcome	
		Hospitalised	Not hospitalised
Prediction	Hospitalised	37 (true positives)	14 (false positives)
	Not hospitalised	15 (false negatives)	137 (true negatives)

The number of true positives and false negatives obtained when diagnosis was excluded and included as a predictor variable was compared. The result was not significant. ($\chi^2(1) = 1.5$, n.s.)

3.5.3 Discriminant function analysis of hospitalisation, using diagnosis alone

When the analysis was completed using only diagnosis as a predictor variable the results were significant $F(1,201) = 107.9$, $p < .01$. This analysis yielded a classification matrix that was identical to that found in chapter 3.5.2 and shown in Table 27.

CHAPTER FOUR

CASE STUDIES

In this chapter five case studies are presented. They were selected to illustrate issues relating to the assessment and psychiatric hospitalisation of defendants at court, particularly the unique experience of each individual. One case study has been selected for each of the pathways to hospitalisation from the courts, that is insanity, disability, guilty and mentally disordered, and compulsory treatment orders (MHA, 1992). A case study of a defendant who was assessed but hospitalisation was not recommended, has also been included. Information has been taken from the Court Liaison Assessment Sheet (Appendix 1), file notes, the police summary of facts, and the psychiatric and psychological reports prepared for the courts. Names and some minor details have been changed to prevent identification. Following presentation of the case studies there is some comment on the themes, apparent from the case studies that are relevant to the current study.

4.1 **HEMI**

Sex: Male

Age: 31

Ethnicity: Maori

Charges: Unlawfully taking a motor vehicle
 Burglary
 Being found in an enclosed yard
 Armed robbery

Outcome: Not guilty by reason of insanity
 Section 115 (1) (b) CJA, 1985 (Special patient)

Background: This man was first admitted to a North Island psychiatric hospital twelve years ago and a diagnosis was made of paranoid schizophrenia. Since that time he has had many exacerbations of this disorder, particularly perceptual disturbances, in that he reports almost constantly hearing voices and seeing visions. Hemi has a long history of substance abuse

including alcohol, marijuana, solvents and benzodiazepines. There had also been difficulties with side effects from his medication. Admissions had become more frequent, over the two years prior to this presentation, and usually lasted between one week and several months. Hemi had discharged himself, against advice, from a rehabilitation ward two weeks prior to the alleged incident. It was thought notable that his medication trifluoperazine, was administered by long acting injection, every two weeks.

Alleged offending: The defendant had been apprehended by the police following an incident in which Hemi and a group of others had attempted to hold up a local video and stereo shop. They had guns as weapons and attempted to escape in a stolen car. On the day of the alleged offending, Hemi acknowledged that he had been using alcohol, but not drugs. He reported hearing and seeing evil and demonic spirits, most of the day. While he did not deny his involvement, he claimed that others initiated it.

History: This man is of Ngati Porou descent, and he has eight brothers and five sisters. Two other family members have been diagnosed with schizophrenia. He was six years old when his father died. School Certificate was achieved on his second attempt, and he began a painting and paper hanging course at polytech. He did not complete it. Hemi had had no contact with his mother for some years, however kept irregular contact with his siblings. In the past, he has had a defacto relationship, and has a seven year son. His ex-partner and her family have opposed access to his son.

Hemi has spent much of his adult life in psychiatric hospitals. At other times, he is described as leading a nomadic existence travelling around New Zealand, and staying with friends or relatives, or in places like the City Mission or on the streets. He had had no stable accommodation or sustained employment, and had tended to mix with other people who have psychiatric or substance abuse problems.

Criminal history: Hemi has had a past conviction for burglary, and served a short prison sentence. He had also been convicted of driving a car without a licence.

Assessment: This man was initially remanded to Addington Prison, under section 121 (2) (b) (i) CJA, 1985 for a psychiatric assessment. He was then transferred to the medium secure psychiatric inpatient unit, Te Whare Manaaki, at Sunnyside hospital for more thorough evaluation (s. 121 (2) (b) (ii) CJA, 1985). He engaged readily in conversation, and did not appear suspicious, but presented as restless and anxious. Hemi believed that the television set was making frequent reference to him, and that other people were both reading his mind and putting thoughts into his head. He reported almost constantly seeing visions, and hearing voices that he referred to as 'demon spirits' and were often derogatory, although sometimes they were perceived to say good things about him. Hemi always wore a hat, which he believed would prevent evil spirits from entering his head. During the time of his inpatient assessment, he was described as almost constantly hallucinating. The content of his talk frequently involved religious matters such as Satan and the devil. He was preoccupied and social interaction was infrequent. On occasions he became distressed and requested medication. His sleep was poor, and he woke during the night complaining of the hallucinations. No difficulties were noted with his orientation or cognitive functioning, and his mood was neither elevated nor depressed.

Conclusion: The psychiatric assessment completed on this man recommended that he be found not guilty by reason of insanity. He had a long psychiatric history that had interfered with his adult socialisation, a florid mental illness at the time of the crime, and severe symptomology that was unlikely to have been malingered. The court accepted this recommendation and he was made a special patient.

4.2 JOHN

Sex: Male

Age: 59

Ethnicity: European

Charges: Unlawful possession of a firearm
Discharge of a firearm in a public place

Outcome: Under disability
Section 115 2 (a) (Committed patient)

Background: Two years prior to this presentation, this man had a cerebral vascular accident affecting the left temporal parietal region of his brain. There appeared to be further deterioration in the two months period, immediately prior to this incident, and it was hypothesised that he may have suffered a further stroke with frontal lobe involvement. He had been briefly admitted to a psychogeriatric ward during this time. His wife was concerned about his inappropriate behaviour, social judgement, and communication difficulties. John spent most of the day and night walking long distances or sleeping, and had been found by police swimming naked in a local swimming pool. He had begun to drink alcohol in an uncontrolled manner, which he hadn't done in the past, and to attend massage parlours. His mood was described as irritable, and he had become more argumentative and distant from his family, but he was not violent. There had also been deterioration in his standard of dress and self care.

Alleged offending: On the day of the alleged offence, John was observed early one weekday morning loading his gun, and shooting it into a river in a suburban area. When asked about this behaviour, he said that he was shooting ducks and did not seem to appreciate the potential consequences of his actions. While John appeared to recognise that he had done something wrong, his concern was that he had been using the wrong type of gun rather than any concern about the dangerousness of his actions.

History: This man had a rural background, and had attended school until the age of 15, and did not have any formal qualifications. Following a number of labouring jobs, he worked for the Post Office for 32 years. During this time he appeared settled, and he had no previous convictions. He married later in life, and had two sons aged 14 and 9 at the time of the presentation. He left his employment following the cerebral vascular accident. Prior to this he had no previous psychiatric history.

Assessment: John was remanded for inpatient assessment (s. 121 2(b) (ii) CJA, 1985). While he was co-operative, there were major difficulties in both expressive and receptive communication. He could not express himself well, either verbally or by writing, and information was conveyed either through drawing or by gesturing. John's answers to questions were concrete, and contained perseverations and word substitutions. He had anomia, in that he was unable to state the name of his wife or children, objects, places or numbers. John was orientated to time, place and person but not to day or to month, and had marked difficulty with time sequencing. He was described as emotionally bland, and did not appear frustrated by his communication difficulties, regarding them in a manner described as matter of fact.

Psychometric assessment was difficult because of communication deficits, however his intellectual functioning was estimated to be in the mentally retarded range, using the Wechsler Adult Intelligence Scale for Adults-Revised (WAIS-R). He did particularly poorly on those subtests, which required a verbal response or verbal concept formation. John did relatively better, however, on tasks requiring comprehension, commonsense judgement, practical skills and visual and spatial skills. On the Wechsler Memory Scale-Revised (WMS-R), he was found to have a very limited ability to retain verbal information over time, and while he also had a limited ability to learn information presented visually, once learnt there was some retention.

During inpatient admission, he appeared relaxed and slept well with no evidence of nocturnal wanderings. Difficulties with communication were ongoing, and often completed with gestures. There was some evidence of sexual disinhibition, in that he was observed to pat

women's bottoms. There was no evidence of hallucinations or delusions, or any other abnormal thoughts or ideas suggestive of psychotic processes.

Conclusion: It was concluded that his behaviour at the time of the alleged offence was almost certainly secondary to neuropsychological damage as a result of his stroke. John was regarded as unable to instruct counsel, and to have a doubtful understanding of the court process. He was found to be under disability, and because he was not regarded as a serious danger to the community, it was regarded that special patient status was not necessary to ensure public protection and he was made a committed patient.

4.3 FRANK

Sex: Male

Age: 40

Ethnicity: European

Charge: Threatening to kill a police officer

Outcome: Guilty and mentally disordered
Section 118 CJA, 1985

Background: This man had not been seen previously for psychiatric assessment, despite endeavours to encourage this from his general practitioner and a counsellor, and significant family concerns. On review, it appeared that he had been having considerable difficulties for at least ten years. Thirteen years previously he had serious injury requiring surgery, and it was that about this time that the family noted progressive social withdrawal, excessive interest in religion, and that he talked to voices. For some years, he had been hearing voices that other people couldn't hear and yet seemed real. While they had no obvious source Frank thought the voices came from the 'cosmic eggs' of the 'tocar'. They were perceived to repeat phrases, such as, 'you are not well in the head'. He would obey voices when they told him to stand in one spot for long periods of time. While the voices were present most days, there had been periods of a few weeks when they had not been present. Frank also reported seeing things that did not exist called 'tu's' and when watching television, bright lights would appear which he thought entered his head.

Nine years previously he had moved to Christchurch, as he believed he was being poisoned by flatmates, and that family members and friends had been killed, and replaced by clones who were attempting to take over his mind. Clones were either blue or green, and proof could be established by sawing off a leg to see if there was a metal rod inside.

Alleged offence: There had been arguments and disturbances at a flat, and the police were called. Frank became aggressive and threatened to kill a policeman, while waving a bread knife around.

On the day of the incident he had been drinking, had only hazy recollections of the events, and could not remember what the altercation was about. He thought he heard voices from the radio telling him that the police were coming to get him.

History: Frank comes from a small rural town. He is the second of four children. The father deserted the family, when Frank was three. Because they were without social welfare benefit, poverty and hard work had marked his early life. Frank did not like school, and was the victim of bullies. However he remained at school until the sixth form, and gained a diploma in horticulture. He had a number of jobs in the horticulture area, and at the time of presentation, had been working part time in a horticultural business owned by his brother. Socially he had been a loner, without close friends of either sex and described by his family as unassertive, passive, and gentle. Most of his life he has lived with his mother, although he did own his own house through conscientious saving. He had had progressively more difficulties in organising his life, and taking care of himself. A maternal aunt had been hospitalised with depression, and his grandfather was an alcoholic.

Frank had no previous convictions and was reported by his family to have been violent on only one occasion, when he destroyed a radio believing that the people on the radio were talking about him.

Assessment: This assessment was completed on an outpatient basis, pursuant to section 121 (2) (a) CJA, 1985. His mother, sister and brother who had been concerned about his mental state accompanied Frank. He was tidily dressed, and his mood appeared normal, and his memory and concentration, satisfactory. Much of the content of his speech concerned delusional beliefs. Frank believed that the musical group, the Rolling Stones made reference to him in their songs and attacked him personally. He described thinking about Men in Black, MIB, time travel, and secret keys to the universe.

Other unusual beliefs included, dentists putting microphones in teeth, trucks really being able to run on water, and people commonly being killed in the garden, and moved before dawn.

At times he had obeyed commands, such as driving through red lights, and following pink lines that appeared before him. Difficulty in sleeping was reported, as he feared laser beams might stab him in the eyes. He wore sunglasses in bed for protection. He believed computers controlled his mind. Frank was insightful into the bizarre nature of these thoughts. A diagnosis of paranoid schizophrenia was made at the time of the assessment.

His dependence on alcohol had been questioned also, and he regularly made home brew and gin. He said that his drinking was currently out of control. Frank occasionally smoked marijuana.

Conclusion: It was concluded that the symptoms of schizophrenia almost certainly played a part in this man's alleged offending. His behaviour was completely out of character, and was marked by misinterpretations and false beliefs, which would have at least magnified any sense of threat from the police. The psychiatric assessor was of the opinion that with treatment and followup, he would not be a danger to public safety. While it was regarded that this man would have an insanity defence, Frank chose to plead guilty, and subsequently an order under section 118 CJA, 1985 was made. Within a week of commencing on antipsychotic medication there was a reduction in the voices.

4.4 PAULA

Sex: Female

Age: 30

Ethnicity: Maori

Charge: Threatening to kill

Outcome: Compulsory treatment order
Section 30 MHA, 1992

Background: The defendant had had many admissions to psychiatric hospitals, throughout the South Island from an early age. Antisocial traits were initially noted, and later a diagnosis was made of antisocial personality disorder, however at the age of 25, bipolar affective disorder was also diagnosed. A brief depressive episode occurred following the birth of her second child.

Alleged offence: The defendant had been attending a meeting with Department of Social Welfare officials, regarding the custody of her three children. Earlier in the year she had been compulsorily admitted, following an exacerbation of her bipolar affective disorder and during this time, her children had been taken into care. As her condition improved, the compulsory treatment order was not maintained, and she discharged herself against advice. This was about a week prior to the meeting. When it became clear that Paula was unlikely to gain custody of her children, as she had expected, Paula became upset and abusive, and threatened to kill one of the social workers with a gun.

History: Paula was reluctant to disclose information about her personal background. From hospital files it was known that she was made a ward of the court, at two years of age, following the separation of her parents. Since that time she had been in numerous foster homes. At the age of 13, she was placed in Dunedin Girl's Home. Most of her adolescence was spent in adolescent units and hospitals.

She had been married twice and had five children. Her first husband had custody of the two older children, and she had regular contact with them. Until her admission earlier in the year,

she had been caring for her three youngest children, aged 4 years, 2 years, and 6 months. She had recently separated from her second husband.

Paula is known to have intermittently used illicit drugs and alcohol, however there was no clear relationship between this, and her previous admissions. It was regarded however, that substance abuse was likely to have been an exacerbation to her bipolar affective disorder, and possibly a precipitant to impulsive and aggressive behaviour.

Criminal history: Paula had had several convictions for theft, disorderly behaviour and damage. Although she mentioned being in Christchurch Women's Prison, she would not expand on this.

Assessment: On initial inpatient assessment (s. 121 (2) (b) (ii) CJA.), this woman appeared agitated, aggressive, and threatening. She refused to answer some questions. It was regarded that some of her thinking was of a delusional nature, and that she had a number of grandiose ideas relating to her belief in her special powers. While some of the more florid psychotic features were alleviated with antipsychotic and mood stabilising medication, Paula remained agitated and impulsive.

Conclusion: Paula was regarded as fit to plead. At the time of the offence, it was regarded as highly probable that she was acting under her own volition, and that her behaviour reflected her antisocial personality traits. A slight elevation in mood, as a contributory factor could not be excluded, however, it was concluded that she did not have an insanity defence. Following discussion with the police prosecutor, there was agreement that the charges be dropped, and that a compulsory treatment order be made.

4.5 MATTHEW

Sex: Male

Age: 40

Ethnicity: European

Charges: Abduction
Sexual violation

Outcome: No psychiatric orders made
Penal sentence

Background: Matthew reported a number of symptoms, dating back three years to the break-up of his marriage. These included difficulty sleeping, lowered mood, and proneness to being tearful, and one month previously he had been prescribed antidepressant medication by his general practitioner. He was also continually worried about a number of other serious charges that he was facing, and about the welfare of his 14 year old son of whom he had custody.

Alleged offending: Matthew was charged following an incident in which late one night he picked up a young woman in his car, and had sex with her. As the car slowed for traffic lights she escaped, and contacted the police. The defendant denied many aspects of the police summary of facts, and intended to plead not guilty. He believed that the woman he invited into his car was a prostitute. On the evening of the alleged offending, he had been drinking heavily.

History: Matthew had one brief psychiatric admission as a teenager, however no diagnosis was made. Matthew was the seventh of nine children, and his early life was characterised by considerable marital disharmony and parental alcohol abuse. Both parents physically abused the children. Matthew attended a number of schools, was frequently truant and left at the age of 14 without qualifications. Until his apprehension, he was self employed as a truck driver, and described as very hardworking.

The defendant had three children to his first wife, who described him as a jealous and possessive man, when contacted. The relationship was affected by Matthew's behaviour of cross-dressing to obtain sexual arousal, and the marriage ended three years ago. The defendant's ex-wife

described an increase in alcohol consumption and assaultiveness, over this three year period, including threats to burn her man-friend's house and malicious phone calls. She had obtained a nonmolestation order against him. Earlier in the year, Matthew's relationship with another woman also broke up, although they subsequently reconciled. She was expecting twins to him in three months time.

Matthew also reported an increased consumption of alcohol, over this time. He described often drinking more than he intended to, and admitted to drinking about a dozen cans of beer, twice a week. He reported blackouts, and that other people had suggested that he reduce his intake. There was no evidence that he used other drugs.

Criminal history: During adolescence, Matthew was convicted on burglary and vandalism charges, his first court appearance being at the age of 15. When he was 18, he spent 18 months in borstal. He has also had two convictions for being drunk in charge of a vehicle.

Assessment: Matthew was assessed whilst he was in custody (s. 121 (2) (b) (i) CJA, 1985). He was co-operative, however his mood was changeable, and at times he was tearful. Since his arrest, the defendant had suicidal ideation, and he had swallowed a number of tablets in an unsuccessful suicide attempt. At the time of the assessment, he stated that he no longer felt suicidal. He reported that his mood was predominantly low, however the assessor did not consider that he was severely depressed. There was no clear evidence of psychotic processes, although some of his thinking during periods of alcohol abuse was of a paranoid nature. While he reported memory problems, and poor concentration, these were not evident during assessment and psychological assessment was not completed.

Conclusion: Matthew was assessed as fit to plead, and as not having a psychiatric defence. He was regarded as having a serious alcohol problem, and although features of depression were noted, these were regarded as possibly being a consequence of his alcohol abuse. It was recommended that if mood disturbance became more evident, whilst the defendant was in custody

that the RFPS would see him, and that if the defendant received a non-custodial sentence, that he undertake treatment for his alcohol related difficulties.

4.6 COMMENT

It is clear from the case studies that each defendant has a unique set of circumstance that led to criminal charges. The experience of each individual within the criminal justice system and mental health system is also unique. In retrospect, it is apparent that many defendants have early signs of psychotic processes, and indeed some people were being followed up by mental health services, albeit with some reluctance, by the individuals involved. The case of Frank illustrates that at times when access to appropriate care is limited for whatever reason, a possible consequence for the individual is that eventually criminal charges are laid with their accompanying stigma.

From review of the case studies, it is apparent that a clear evidence of psychosis is most often a necessary condition of recommendations of hospitalisation. The case of Matthew shows that, even though he had a recent history of self harm, he was at risk of harming others, and showed evidence of depression, this was not sufficient justification for hospitalisation. The seriousness of the charges he faced however also is likely to have influenced his outcome. Indeed, it is possible that when defendants face serious charges, there is some reluctance to recommend psychiatric hospitalisation, either because this might not be accepted by the court or because of accompanying management difficulties.

In many cases there were complications with alcohol and drug abuse. Hemi had major substance abuse difficulties, and was under their influence at the time of the crime yet was found not guilty by reason of insanity. Matthew, also had difficulties in this area and was under the influence of alcohol at the time of the crime, yet did not have a psychiatric defence. Alcohol and drugs were regarded as exacerbating Paula's bipolar affective disorder. This raises the issue of responsibility for this behaviour. Criminal behaviour can result from the consequences of addiction that becomes beyond the individual's control. While it is possible that some people self-

medicate with alcohol and nonprescription drugs, in order to control disturbing psychotic symptoms, it is also possible that the same factors that lead to alcohol and drug abuse amongst many criminal defendants also lead to alcohol and drug abuse amongst defendants who are hospitalised. Intervention in this area is warranted for many defendants, regardless of the outcome of their court proceedings.

The case of Frank also illustrates the role of the individual in influencing to some degree the legal outcome of their case. It is not typical of section 118 CJA, 1985 hospital orders but it does demonstrate that outcome to some extent is a consequence of the defendant's plea. Frank was regarded as having an insanity defence, but he chose to plead guilty, and hence his outcome was guilty and mentally disordered, and a section 118 CJA, 1985 hospital order was made. In many other cases where this outcome was recommended to the court, defendants were not regarded as having an insanity defence. It appears that section 118 CJA, 1985 hospital orders are used to cover a wide range of individual circumstances.

The case studies also show the importance of family and personal interpersonal relationships. The charges that Paula faced arose out of a situation, where she perceived that she was being denied custody of her children. Frank's family were aware that something was wrong with him, yet were unable to effectively respond to this. John's family appeared to be closely monitoring his progress following his stroke, and Matthew's difficulties were dated back to a marital break-up. The extent to which individuals and family members fully understood the process that defendants underwent, is not clear. It seems likely that many were not aware of how decision making was made, and how they might influence it. The eventual outcome of the legal proceeding had an impact on family and friends as well as the defendant.

The issue of dangerousness is controversial. Assessments of dangerousness are not specifically requested by the courts (s. 121 (1) CJA, 1985), yet it appears that this issue was routinely addressed in the psychiatric reports prepared for the courts and that it has an impact on the recommendations that were made. Hemi was regarded as dangerous, and became a special

patient. John however, was regarded as not having a high likelihood of future dangerous behaviour if supervised, and became a committed patient. This raises the issue of the potency of psychiatric evaluations of dangerousness at court, and also the methods and efficacy with which these decisions are reached.

CHAPTER FIVE

DISCUSSION

5.1 DISCUSSION OF RESULTS

In this section the outcome of the court proceedings, which was used to determine the independent variables is first discussed. This is followed by consideration of referral patterns and information, because sequentially it is the first stage in the process of CLS contact. Demographic information, criminal information, victim information, family information, psychiatric history, alcohol and drugs, suicide, mental status and diagnoses are then discussed. In these sections, the characteristics of the total sample are considered, as well as the comparisons between the group who received a psychiatric report, and the group who did not, and the comparisons between the group that were hospitalised, and the group who were not. The results of the prediction of psychiatric report and hospitalisation are then discussed, and the role of psychosis in decision making about hospitalisation explored. The results of the current study are compared where appropriate, with those available from comparable research studies. The New Zealand CLS studies of Peters and Wade (1996) which was conducted in Auckland, Brinded, Malcolm et al. (1996) which was carried out in Wellington, and Roberts (1996) from Christchurch are emphasised.

5.1.1 Outcome of the court proceedings

Over the three year period between 1992 and 1994, 572 screening assessments were completed by the CLS in Christchurch, resulting in 566 transactions. A total of 522 people were seen. Following CLS screening, the court ordered a psychiatric report in 42.7% (242), of all transactions. These cases formed the report group, in the current study.

When the final outcome of the court proceedings was known, 2.0% (11) of the total sample was found to be legally insane and 0.7% (4) under disability. An additional 2.9% (16)

received a hospital order under section 118 CJA, 1985, and 5.9% (33) were the subject of compulsory treatment orders. In total, 11.4% (64) were hospitalised as an outcome of their court appearance and made up the psychiatric group in the current study. Two people, who had their charges withdrawn, upon agreeing to hospitalisation on a voluntary basis, were excluded. Consistent with international research, the proportion of all defendants who are psychiatrically hospitalised, as a consequence of court proceedings was very small.

Unsurprisingly, 25.1 % of all transactions resulted in a penal sentence, and 43.1% in a community sentence. Overall, 6.4% had their criminal charges withdrawn and the defendant agreed to community intervention, such as attending an anger management course. This is a considerable proportion, and suggests that the CLN may have had an impact on these decisions, in proposing a mental health solution to the difficulties that resulted in the defendant's court appearance. This hypothesis could be tested, by comparing the percentage who received this outcome, with and without the presence of the CLS during legal proceedings. It implies also, that on occasions, the police do not necessarily want prosecution, but rather to know that something is being done about problematic behaviour. They may be reassured by the fact that there is some consequence, regardless of whether it is punitive or therapeutic. It is likely that this option is used only when the charges involved are minor, and Roberts (1996) has proposed that it is likely also, when the defendant was a first offender, and the police regard that the individual involved would benefit from this course of action.

5.1.2 Referral information

Referral agents

All the New Zealand studies have found that referrals come from a wide range of agents, with most coming from solicitors and the police. In the current study 40.3% of the total referrals to the CLS, come from legal counsel and duty solicitors, who are likely endeavouring to gain the best service for their clients. The police referred 36.7% and smaller numbers were referred from other courtroom staff, mental health professionals, and people like general practitioners. These percentages are similar to those found by Roberts (1996), who reported that 35.6% of referrals come from solicitors, and 37.3% from the police. The referral sources reported by Peters and Wade (1996) are also similar, in that they reported that 43.0% were referred by counsel and 32.8% by police. Brinded, Malcolm et al. (1996) reported that 28.6% of referrals were from defence counsel and duty solicitors and 34.6% were referred by the police. Peters and Wade (1996) found that 5.8 % were referred by family members, and 4.2% self referrals were made. In the current study, 2.4% of referrals were made by family members, which was defined to include self referrals. Possibly the option of CLS referral is not as well known to defendants and their families in Christchurch, as in Auckland, where the CLS has been available for a longer period of time and has received publicity.

In the current study, when comparison was made between the group who received a psychiatric report, and the group who did not, it was found that the police refer proportionately more of those who receive a psychiatric report. Duty solicitors, probation officers, and the judge made fewer referrals that resulted in psychiatric evaluation. There were no significant differences in referral sources, between those who were eventually hospitalised, and those who were not. It is possible that the police are better referral agents, in that they are better trained, or are more experienced in making appropriate referrals to the CLS. They may have more familiarity with the person involved, which enables them to do so. This finding is somewhat in contrast with that reported by Steadman, Morrissey, Braff and Monahan (1986) who compared people who were

brought by the police to a New York emergency room, with those brought by other sources. Patients, whom the police referred, were found to be less mentally disordered, and they less often met the criteria for involuntary commitment, than those referred by other sources. The authors emphasised, however, that this does not mean that these people would not benefit from mental health treatment. It may well be appropriate to assess these cases, even if it does not result in compulsory admission. The same argument can be applied to the current findings, in that because a referral does not lead to full psychiatric evaluation, it does not mean that the referral was inappropriate.

Summary

- (1) *Most CLS referrals came from solicitors and from the police.*
- (2) *The police referred proportionately more of those who received a psychiatric report, compared with other referral agents.*

Reasons for referral

When the reasons for referral were considered in the current study, 19.7% were referred on the basis of their history of contact with mental health services or that of their family members. Brinded, Malcolm et al. (1996) reported that 23.7% were referred for this reason, and Peters and Wade (1996), 23%. In the current study, 27.9% of referrals were made in order to determine the defendant's mental state or whether he or she was psychiatrically unwell. Peters and Wade (1996) reported, that 18% were referred for assessment with regards the possibility of mental illness and Brinded, Malcolm et al. (1996) stated that 47.4% of referrals, related to the possible presence of a psychiatric disorder. In the current study, 11.3% of referrals were made on the basis of concerns about the defendant's levels of dangerousness, either to him or herself or another person. Brinded, Malcolm et al. (1996) reported that 11.7% of referrals were made in order to evaluate suicide risk. Peters and Wade (1996) did not include a comparable category in their study, however the 26% of referrals, made on the basis of odd or unusual behaviour, may have included those who were referred because of concerns of this nature. In the current study, 12.5% of

referrals were made on the basis of the defendant's presentation, and 16.5% because of the nature of the charge, which included cases such as assault on a small child, a large armed defenders call out, or other notable features. Comparison between these studies is complicated by the fact that each has used different methods of categorising the reasons for referral.

The significant difference between the given reasons for referral between those who were eventually hospitalised, and those who were not, was accounted for largely in terms of the greater proportion of those who were not hospitalised, being referred because of concerns about dangerousness. It may well be that when referral agents are considering the level of dangerousness, they refer defendants to the CLN as a mental health professional, who is readily available in court.

Golding and Roesch (1987) proposed that referrals for psychiatric evaluation are sometimes triggered by considerations unrelated to the defendant's mental state. They raised the possibility that there is confusion amongst attorneys, with regards the role of mental disorder in adjudication, and that mental health referrals might occur to accomplish other goals, such as assistance in preparing a case, or to effect a delay in proceedings. The extent to which this might apply in New Zealand is unknown, however the presence of CLS at court would presumably reduce these possibilities.

A considerable proportion (9.1 %), of all screening assessments, reviewed in the current study, were completed on defendants who were seen on more than one occasion during the period of the study. In the total sample, 20.7% of those seen by the CLS had had previous contact with forensic services. They may have been seen previously at court, or have had contact with the RFPS by some other route. Not surprisingly, the proportion of those previously seen was greater, amongst the group who received a psychiatric report, compared with those who did not, and also, amongst those who were eventually hospitalised, compared with those who were not. This suggests that a sizeable minority of defendants seen by the CLS are recidivist offenders, with significant mental health problems and repeat contact with mental health professionals. They

have the features of the 'revolving door' concept of mental health delivery and absorb a notable amount of social resources. The fluctuating and cyclic nature of major mental illness, such as schizophrenia and bipolar affective disorder, may be a reason for this, along with poor medication compliance, however it does raise issues relating to effective treatment and followup.

Summary

- (1) *Defendants were referred for a wide range of reasons, including a history of psychiatric illness, in order to determine the defendant's mental state, and factors relating to the unusual nature of the charge.*
- (2) *Defendants, who received a report, but were not subsequently hospitalised, were more often referred because of concerns about dangerousness.*
- (3) *About 20% of defendants had had previous contact with the RFPS.*

5.1.3 Demographic information

Gender

The percentage of females that were referred to the CLS in the current study (12.8%), is comparable with the 13.3% reported by Roberts (1996), the 19% found by Peters and Wade (1996), and the 20.3% reported by Brinded, Malcolm et al. (1996).

Table 28

Percentage of females in various studies

General population ¹	50.7	
Police apprehended offenders ²	21.9	
Prison population ³	3.7	
Current study	CLS referred defendants	12.8
	Defendants who received a report	8.7
	Defendants who were hospitalised	2.0

¹New Zealand Official Year Book (1996). General population census 1991.

²Statistics NZ (1996). Offenders apprehended 1995.

³Lash (1996). Census of sentenced inmates 1995.

Table 28 compares the percentage of females found in the current study, with those found in the general population, police apprehended offenders, and the prison population. The dates of the various investigations, and their methodologies were not the same, however they all refer to studies conducted in the first half of the 1990s. Although, only slightly fewer than one in four offenders apprehended by the police is female, most sentenced prison inmates are male. This is because females are most often apprehended on dishonesty offences, such as fraud and shoplifting, (Statistics New Zealand, 1996), which are less serious crimes, and are less likely to lead to a prison sentence. Males in contrast, commit more serious crime, which more frequently leads to a penal sentence.

Compared with the prison population, proportionately more females were referred to the CLS. Thus, while males are grossly over represented in the prison population, there is a

suggestion that females may be over represented amongst those referred to CLS. This finding is consistent with the international studies described previously (chapter 1.2.6), which found an over representation of females, in samples of those referred for psychiatric evaluation, compared with prison samples. The proposal of Zonana et al. (1990), which suggested that a reason for this might be that mental health explanations for criminal offending might be more readily sought, and more socially acceptable for females, possibly applies in New Zealand also.

It is likely however, that there is some interaction with the seriousness of the charges, in that defendants facing minor charges may be less often referred to the CLS. Also, a condition of the court ordering a psychiatric report, is that the defendant face charges for which they might be imprisoned (s. 121 (1) CJA, 1985). The current study found that there were significantly fewer females in the group, for whom a report was ordered, compared with the group for whom they were not ordered, and only one female was psychiatrically hospitalised. The percentage of females, who were psychiatrically hospitalised, approximates the proportion in the prison population. Caution is required in interpretation however, because the numbers involved are very small.

These findings imply that possibly, there were more inappropriate referrals of females to the CLS. When a female defendant presents, there may be more willingness by people, such as the police and solicitors, to explore the possibility of psychiatric factors being involved in the offending. The assessing nurse, however who screens these referrals may be more objective in detecting psychiatric factors, regardless of gender, and subsequently the proportion who are hospitalised, is similar to that found amongst the prison population. However, this explanation raises the issue as to whether the proportion of those who are psychiatrically hospitalised, should be similar to the prison population. Psychiatric evaluation and hospitalisation might be more or less warranted for females, for reasons related to the actual incidence of mental health issues amongst females generally, or females who criminally offend. Probably because the overwhelming majority of criminal defendants are male, the facilities available specifically for

females within the forensic units, of psychiatric hospitals, are relatively poor. There may be some reluctance to recommend psychiatric admission for females, given the knowledge that appropriate accommodation is unlikely.

Summary

- (1) *Relative to the prison population, there was an over representation of females amongst defendants referred to the CLS.*
- (2) *This may be because they face less serious charges than males, or because mental health explanations for offending are more readily sought for females.*

Age

In the total sample, the mean age was 30.3 years. Amongst the males, the mean age was 30.6 years and females were only slightly younger, with a mean of 28.9 years. This is older than the age of prison inmates. Lash (1996) reported that the modal age for male sentenced inmates was 20 to 24, and 30 to 34 for sentenced females. In their sample, Peters and Wade (1996) found that 43.9% of their sample of both males and females, were in the 20 to 29 year age group, and 25.4% between 30 and 39. Brinded, Malcolm et al. (1996) reported that the average age for males was 29.8 years, and for females 33.6 years, which is very similar for males, and only slightly discrepant for females, likely reflecting the relatively small numbers involved. The age of females, in both the Brinded, Malcolm et al. (1996) study and the current study, approximates the age of the prison population. It appears that the age of females referred to the CLS in New Zealand, is most likely a reflection of the age of female criminal defendants generally. Male criminal defendants however, who are referred to the CLS in New Zealand, are older than the population of male criminal defendants generally. Consistent with overseas studies (chapter 1.2.6), the group for whom a psychiatric report was ordered was older than the group who did not receive a full psychiatric evaluation. The reasons for these findings are not evident, but may include the possibility that it takes longer for a person, especially if he is male, whose criminal offending is related to mental health issues, to come to the attention of the authorities. People with

psychopathic traits start offending at young ages, and they are typically excluded by psychiatric screening. It is also possible that there is an interaction with ethnicity. Maori people, who are younger, appear to be under represented amongst those referred to the CLS.

Summary

- (1) *CLS referred defendants, tended to be older than imprisoned offenders.*
- (2) *Defendants, who received a report, were older than those who did not.*

Ethnicity

Maori made up 16.7%, and Pacific Islanders 1.8%, of the total sample referred to the CLS in Christchurch, in the current study. This compares with the rates of 37% Maori and 12% Pacific Islanders found by Peters and Wade (1996), and the 29.4% Maori and 9% Pacific Islanders, reported by Brinded, Malcolm et al. (1996). This pattern of findings reflects, to some extent, the regional differences in ethnic distribution, evident in the New Zealand general population, in that higher percentages of Maori and Pacific Islanders are found in the northern regions. This confounds direct comparison between the New Zealand studies.

Table 29

Percentage of people of Maori descent, in various studies¹

General population ²	15.4	
Police apprehended offenders ³	38.0	
Prison population ⁴	49.7	
Current study	CLS referred defendants	16.7
	Defendants who received a report	16.5
	Defendants who were hospitalised	18.4

¹Includes mixed ethnic descent

²New Zealand official year book (1996). General population census 1991.

³Statistics NZ (1996). Offenders apprehended 1995.

⁴Lash (1996). Census of sentenced inmates 1995.

Table 29 compares the results of the current study, with the percentage of Maori people found in the general population, police apprehended offenders, and the prison population. Caution is required when comparing these studies, because of the different ways in which ethnicity has been identified and classified. Maori people are over represented amongst police apprehended offenders, and the prison population in New Zealand, and this probably reflects the youthfulness of the Maori population. Young people commit most crime (New Zealand Statistics, 1996). The New Zealand Official Yearbook (1996) reported that 70% of the Maori population are under 30, in contrast with 43% of Europeans, and 56% of the general population. The percentage of Maori defendants, who are referred to the CLS, is notably less than that found in the prison population, which suggests that Maori people are referred less often. It is also possible that people of Maori decent, may be more reluctant to accept referral, and to view it as useful. Psychiatric explanations for criminal offending may be sought less often for Maori defendants, yet there is no reason to suspect that psychiatric disorders should occur less frequently amongst these people. Bakker and Riley (1993), who reviewed referrals to

Psychological Services of the Justice Department reported a similar result. They found that, while Maori appear to benefit from treatment to the same extent as people of European descendant, they were referred at a lower rate than other racial groups. The percentage of Maori people who received a psychiatric report and who were psychiatrically hospitalised was remarkably consistent.

Summary

- (1) *Relative to the prison population, there was an underrepresentation of people of Maori descendant, amongst defendants referred to the CLS.*
- (2) *A mental health explanation for etiology may be sought less often for Maori defendants, or they may be more reluctant to accept referral.*

Other demographic factors

Consistent with the international research, described in chapter 1.2.6, New Zealand studies of criminal defendants referred to CLS, all report high percentages of people whose relationship status is single. In the current study overall 68.7% were single, 17.5% were separated or divorced, and only 8.7% were reported to be married. These findings are similar to the 67.2% defendants of single marital status, reported by Peters and Wade (1996), and the 71.3% found by Brinded, Malcolm et al. (1996), for males. The New Zealand Official Year Book (1996) reported that, at the time of the 1991 census, 34.9 % of males in the general population were 'never', and Lash's (1996) review of the living arrangements of sentenced male inmates, just prior to entering prison, reported that 40.8% were 'living with partners'. Thus, the high proportion of single people, in samples of criminal defendants referred to the CLS, is likely to be a reflection of the high percentages amongst all criminal defendants. The different ways, in which information about marital status was coded between studies, confounds direct comparison. For example, 'living with a partner' does not directly equate with currently being single.

In the current study, 32.5% reported that their current living situation was flatting or boarding, which is in contrast to the rate of 69.9% reported by Brinded, Malcolm et al. (1996)

and has possibly occurred because of difficulties in retrospectively coding this variable. Overall, 28.1% were found to be living with their family of origin, and only 20.6% reported that they lived with a partner, or had established their own families. This is most likely a reflection of their marital status. When a comparison was made, between the group who received psychiatric evaluation, and those who did not, the group who received a psychiatric report were less likely to be living in partnerships or with their own families. This is consistent with literature which documents that many of those who have psychiatric disorders have difficulty establishing and maintaining satisfactory intimate, and marital relationships (Gelder, 1986). It may also be that those with mental health issues are more difficult to live with. Notable, also in the current study, was the 13.2% who were recorded to be of no fixed abode or were living in camping grounds. Brinded, Malcolm et al. (1996) reported that 13.6% of their male sample were homeless. Thus a sizeable minority of criminal defendants, referred to the CLS in New Zealand, does not have stable accommodation.

When employment status is considered, it is a consistent finding that only a small percentage of those criminal defendants referred to CLS, are in paid employment. The current study found that 17.4% were employed, and Peters and Wade (1996) reported that 14% of their sample were. Brinded, Malcolm et al. (1996) found that 29% of males were working in unskilled labouring jobs, and only 2.8% in professional occupations. Lash (1996) reported that immediately prior to receiving prison sentences, 62.1% of males were on benefits and 31.3% in paid employment. Thus, it is most likely that low levels of employment are typical of all criminal defendants, regardless of whether or not they are referred to the CLS. Again this finding is consistent with international research, described in chapter 1.2.6.

The high rates of defendants on sickness related benefits, or accident compensation is noteworthy. While there are some difficulties in making direct comparisons, in that the categories used do not exactly equate, the current study found that 29.4 % were on benefits of this nature. Peters and Wade (1996) reported that, 19% were on sickness benefits and a further 10% were

'beneficiaries'. This would likely include some who were on the domestic purposes benefit. Brinded, Malcolm et al. (1996) found that 93.7% of their male sample received 'some form of Government paid benefit'. Presumably there was some overlap in this sample, between people both working and receiving some form of benefit.

Attempts were made in the development of this study, to code the variables of socio-economic status, using the scale described by Elley and Irving (1985). This was not proceeded with, because of the small numbers of subjects who were in paid employment. Those that were self employed, at times listed occupations such as prostitution, or drug dealing which did not readily fit into Elley and Irving's (1985) framework. Overall, the impression was that defendants were of low socio-economic status, which is consistent both with international literature and other demographic characteristics, considered in the current study.

Attempts to code the education level of defendants were also abandoned, because there was frequently insufficient information recorded, to enable categorisation. There was also some inconsistency in the recording of this information, in that for some cases, the length of time at school was noted, and for others the highest level of educational attainment was reported. The difficulties in the consistent recording of education may be in part, a reason for the discrepant findings with regards to education that are found in the international literature (chapter 1.2.6). Review of these records, however, suggested that there were low levels of educational attainment and high rates of early school leaving, amongst criminal defendants referred to the CLS.

When comparisons were made, on the variables considered in this section, between defendants who were psychiatrically hospitalised, and those who were not, none reached significant levels of difference. In the comparisons between those who received a psychiatric report and those who did not, only the variable of accommodation was different between the two groups. The base rates of the variables indicative of social disadvantage appears to be very high, amongst all criminal defendants, regardless of whether they receive psychiatric screening, or evaluation or not. This profile of disadvantage is consistent with international research, such as

Joseph's (1990) study of criminal defendants referred for psychiatric evaluation in London, which emphasised the lack of attachment in terms of relationships, and stable accommodation. The high base rate may have made it difficult to detect significant differences. However, the overall findings are theoretically consistent with psychiatric evaluation and hospitalisation reflecting no overt biases. Social disadvantage, in terms of factors like marital status, accommodation, employment, and socio-economic factors, appears to characterise criminal defendants generally, as well as defendants referred to the CLS.

Summary

- (1) *Criminal defendants referred to the CLS are clearly socially disadvantaged. They are infrequently married, or in employment, have poor accommodation arrangements, and appear to be of low socio-economic status, and education.*
- (2) *This is a robust finding that occurs across jurisdictions.*
- (3) *Few differences were found in the demographic characteristics, between the group who received a report compared with those who did not, and between the group who were hospitalised, and those who were not. This is likely because of the high base rates of factors reflective of social disadvantage.*

5.1.4 Crime information

In the current study, 81.3% of the defendants referred to the CLS, had a history of previous conviction, which is similar to the 86.2% of male sentenced prisoners, reported by Lash (1996). It is also similar to the findings of Joseph (1990) who reported that only 21% of those referred to a similar service in London had no previous convictions. Information about previous convictions was not reported in the other New Zealand studies. Brinded, Malcolm et al. (1996) reported however, that at the time of the alleged offence 12.2% of men, referred to the Wellington CLS were already on bail, and 4.2% were serving sentences of periodic detention. These figures suggest a relatively high level of involvement with the criminal justice system. While most defendants, regardless of whether they are referred to the CLS or not, have a history

of previous involvement with the criminal justice system, the severity and frequency of past convictions was not known in the current study. International research discussed in chapter 1.2.6 suggests that prior criminal offending by those who are found not guilty by reason of insanity may be of a less serious nature than those who are criminally convicted. The current study found that significantly more of the group, who were psychiatrically hospitalised, had a history of past offending. The reasons for this are not clear.

The high rate of previous criminal charges adds to the portrait of social disadvantage, and again base rates amongst all criminal defendants are high. Frequent past criminal conviction appears to be true for all criminal defendants, whether or not they are referred for psychiatric screening or evaluation, and whether or not hospitalisation is the outcome of the legal proceedings.

When the most serious offence for which the defendant faced charges was considered, the range reflected all types of criminal behaviour. In the current study defendants referred to the CLS, most frequently faced charges relating to violence. The rate of 38.7% is higher than the 19.4 % reported by Peters and Wade (1996), but is similar to the 41.6% charged with offences against the person reported by Brinded, Malcolm et al. (1996) for males. Peters and Wade (1996) used a larger number of crime categories than the other studies, which may to some extent, have resulted in the discrepant findings with regards the incidence of violent crime amongst defendants referred to CLS, and confounds direct comparison. Spier (1996) reported that in 1995, 12.1% of all convictions in New Zealand, except traffic offences, involved violence. This figure refers to total number of convictions and not the most serious conviction, as was used in the current study. There is likely to be some interaction with seriousness of offence, in that a psychiatric report cannot be compelled by the court, unless the defendant faces charges that may result in a prison sentence. Both the current study, and Brinded, Malcolm et al. (1996) found that 35% of defendants, referred to CLS, faced charged related to property offences, which compares with the 44.3% of all convictions in New Zealand (Spier, 1996). In the current study, smaller but notable

numbers, faced charges relating to sexual offences, the misuse of weapons, drugs, and traffic violations.

Attempts to code the seriousness of the offence to which the defendant faced charges, using the scale provided by Spier, Luketina and Kettles (1991) were discontinued, because there was insufficient information available to enable effective ratings of the seriousness. Scales of offence seriousness, such as this one, and the more recent version described by Spier (1996), require relatively detailed information about the nature of the charge. Assault, for example, receives a different rating, depending on whether a police officer is assaulted or another person. Attempts to average the seriousness rating given to assault were not possible, because it led to the insensible consequence that property offences received a higher rating of seriousness than assault.

Summary

- (1) *Most defendants, who were referred to the CLS, had a history of prior criminal convictions.*
- (2) *They faced charges relating to all types of crime.*

5.1.5 Victim information

Where information about victims was reported or relevant, in the total sample 68.8% of the victims were female, and 72.3% of the alleged crimes were domestically related. While the gender of the victim, and the circumstances of the crime, did not differentiate those who received a psychiatric report, victim characteristics were related to psychiatric hospitalisation, as an outcome of the court appearance. More of the victims of those defendants that were hospitalised were males, and the alleged offending was less often related to domestic issues. This finding is somewhat in contrast, to an earlier study by Phillips and Pasewark (1980), which found that within insanity acquittees samples, a family member was most likely to be the victim. However in the current study, the proportion of the alleged offending by those who were eventually

hospitalised, which appeared to be related to domestic circumstances was 43%. This finding is in keeping with the nature of psychotic thinking, which can involve family members, but may also involve the inclusion of people who are strangers, and are connected to the offender in only minimal or circumstantial manner. Possibly, unlike a sizeable proportion of the crime committed by convicted offenders, it does not necessarily arise because of the stressors involved in conflictual relationships and unsatisfactory social circumstances.

Summary

The victims of those who were psychiatrically hospitalised compared with those who were not were more often male, and less often domestically involved with the offender.

5.1.6 Family information

Only 11.1% of the total sample had family support, and 60.7% were rated as having family disruption or conflict. These variables occurred at similar frequencies, between the group who received a psychiatric report, and those who did not. Levels of family support were also similar between those whose eventual outcome was hospitalisation, and those for whom it was not. There was, however, evidence of more family disruption in the group who was sentenced in the criminal justice system. It may be that in the absence of mental illness, family disruption is either directly related to the etiology of crime, or is correlated with it. Family information was classified in the current study in a rather gross manner, into the absence or presence of family support, or disruption. Dichotomous categorisation of family support, or disruption, are poor measures of complex aspects of family functioning.

Summary

- (1) *In the current study family support appeared to be poor, and was similar between the groups that were studied.*
- (2) *There was some evidence that there was more family disruption and conflict amongst the group of defendants who were psychiatrically assessed, but not hospitalised.*

5.1.7 Psychiatric history

Rates of prior contact with mental health services were high, which was to be expected. In the current study, 70.2% had previous contact with mental health services, and 44.7% prior inpatient admission. Brinded, Malcolm et al. (1996) reported that, 56.3% in their sample had prior contact with mental health services, and 44.8% inpatient admission. The rates of previous inpatient admission are lower than the 77% found in the study by Joseph (1990). While it is clear, that only slightly less than half of defendants, referred to the CLS in New Zealand, have previously been psychiatrically hospitalised, the discrepancy with regards prior contact with mental health services, may have to do with how this variable was operationalised. In the current study, any assessment or contact was coded, including alcohol and drug treatment, self help groups or contact with people, such as counsellors. It seems likely that the Brinded, Malcolm et al. (1996) study used criteria, more reflective of contact with psychiatrists only. At the time of the court appearance, a reasonably large number (20.5%), were being followed up by mental health agencies, which raises some question about the efficacy of this monitoring.

Not surprisingly, past psychiatric history was significantly more frequent, amongst those CL referred clients who received a psychiatric report, compared with those who did not. It was also significantly more frequent, amongst those who were hospitalised, as a consequence of their court proceedings. Psychiatric history was also an effective and strong component in the discriminant function analyses, predicting both the criteria of completion of a psychiatric report, and the criteria of psychiatric hospitalisation, discussed below (chapter 5.1.12 and 5.1.13).

Summary

- (1) *Most defendants referred to the CLS had a history of prior mental health treatment.*
- (2) *This was more frequent amongst those who received a report, and amongst those who were hospitalised.*

5.1.8 Alcohol and drugs

In the total sample, 51.1% acknowledged a history of difficulties with alcohol and/or drugs, and 20.7% had had treatment for their substance abuse. Because these figures refer to an acknowledged history, they are probably an under estimation of the actual incidence of difficulties in this area. Most used either multiple substances or alcohol alone. In their epidemiological study of sentenced inmates, Brinded, Fairley et al. (1996) assessed 71% of males and 19% of females, as having a lifetime diagnosis of alcohol dependence, and 42% of males and 9% of females, as having a lifetime diagnosis of cannabis dependence. Amongst sentenced males, 37% had a lifetime diagnosis of anxiolytic dependence, 25% stimulant dependence, 34% opioid dependence, 17% hallucinogen dependence, and 13% cocaine dependence. In this report, the extent of polydrug abuse is unclear.

In the current study, 28.9% were either under the influence of alcohol and/or drugs at the time of the crime, or were rated as likely to have been so. Brinded, Malcolm et al. (1996) reported that CL staff had rated alcohol and drugs to have been a significant contributor to the presentation of 62.9% of the males in their sample, and 54.8% of the females. Differences in how these variables were assessed likely contributes to these variations. In the current study, retrospective ratings were made in a conservative fashion. The extent to which the defendant had been questioned, in this area was unclear. This is distinctively different methodology, than a prompting question at the time of the assessment, which is what appears to have occurred in the Brinded, Malcolm et al. (1996) study.

While the link between substance abuse and the etiology of criminal behaviour has been debated in the literature (Whitney, 1992), it is clearly a major issue for this group of criminal defendants. There were no significant differences, in the alcohol and/or drug histories between the group who received a psychiatric report, and those who did not. However, significantly more of those for whom a report was not ordered, were rated as likely to have been using alcohol and or drugs at the time of the crime. There were no differences, in terms of substance abuse history,

or intoxication at the time of the alleged offence, when those who were eventually hospitalised, were compared with those who were not. The often bizarre and disorganised behaviour, related to alcohol and/or drug difficulties, can mimic signs of mental illness, and this finding suggests that, many of those whose criminal offending was the result of alcohol and/or drug abuse are effectively screened out by the CLN. This implies that, an effective outcome of the CLS, is the prevention of a group of defendants who likely have significant alcohol and/or drug difficulties from inappropriate referral for full psychiatric evaluation.

Summary

- (1) *Half of all defendants in the current study, acknowledged difficulties with alcohol and/or drugs.*
- (2) *About a third, were under the influence of alcohol and or drugs, at the time of the alleged offending.*
- (3) *Defendants, who were not hospitalised, were more likely to have been using substances at the time of the crime.*

5.1.9 Suicide

In the current study, overall 16.2% reported a history of prior suicide attempt, and 42.7% were rated at the time of the CL assessment, as being at moderate to high suicide risk. There were no differences, when comparisons were made between the group who received a psychiatric evaluation, and those who did not. Surprisingly, significantly fewer of the group who were eventually hospitalised, had histories of prior suicide attempts, and fewer were rated as being at high to moderate suicide risk. In the Brinded, Fairley et al. (1996) study, 51% of female sentenced prisoners reported past suicide attempts, and 43% of males. Past history of suicide attempts, is one of the parameters considered in determining risk. The higher rates found in the Brinded, Fairley et al. (1996) study, may have occurred because of more systematic questioning in this area, and the figures found in the current study, are possibly an under estimation in that it is not clear whether this information was consistently probed for. Holley, Arboleda-Florez, and

Love (1995), controlling for factors including age, and gender distribution in the population, estimated that remanded offenders, were over 11 times more likely to report a past suicide attempt. It is a clear conclusion that many criminal defendants are of considerable risk of suicide. Two of the defendants in the current sample, committed suicide over the time of their court involvement. The time of the CL screening is also relevant, in that the suicide risk of imprisoned offenders is greatest during periods of remand or initial confinement (Zamble & Porporino, 1988).

Summary

- (1) *A large number of defendants referred to the CLS, were rated as being of moderate to high suicide risk.*
- (2) *This was more frequent amongst defendants, who were not hospitalised.*

5.1.10 Mental status

As part of the screening conducted by the CLN, a mental status examination was completed on all those who were referred. The results for the total sample of CLS referred clients, constitute a useful baseline for other studies, particularly those of imprisoned offenders.

Overall, a considerable number of observations were made of difficulties in a variety of areas. It is noteworthy that within the total sample, there were numerous observations suggestive of depressive disorders and psychotic processes.

When defendants were asked about their mood and observations were made, almost a third (29.4%), were rated as depressed, and 17.2% anxious. These ratings, however, do not inform about severity, and each of these emotional states may have been transitory, given the situation, or reflective of more substantial difficulties. The thought content of considerable numbers was also rated as very focused on their current stressors (13.0%), often to such an extent that they found it difficult to concentrate.

In slightly less than a third of the screening assessments that were completed (28.6%), observations were made about the nature of the defendant's form of thought, in that it was rated as constrained or pressurised or disorganised. These features raise the hypothesis that the

defendant may be psychotic. In 11.3% of cases, the possibility of delusional thinking was raised. The differential diagnosis of delusions is difficult, given that it is frequently based on factors, such as the degree of belief in the misinterpretation. Also there are other symptoms such as the intrusive thoughts associated with post traumatic stress disorder, which mimic true delusions, and it appears that if there was any doubt, the case was referred for further evaluation. Fewer observations about the possibility of hallucinations were made (3.4%), which is not surprising given the relatively low incidence of hallucinations, even amongst the severely mentally ill. However notable observations about the nature of the person's perception, were made in an additional 7.4% of cases.

In about a quarter of the cases seen by the CLS, some form of memory difficulty was noted. This rate is relatively high, and may reflect the wide range of possible memory difficulties, the high rate of substance abuse, and the possibility that some defendants who answered affirmatively to this question, when in fact their cognitive functioning was within normal limits. Only a quarter of defendants, were described as having satisfactory insight into the nature of their personal circumstances. Lack of insight in some cases might have been indicative of mental illness. It might also have been a consequence of relatively low levels of intellectual functioning or cognitive rationalisations about the court appearance.

Significant differences were found for all of the mental status variables, between the group who received psychiatric evaluation and report, and the group who did not. All of these differences were in the expected direction, in that those who received a report showed more indications of mental health problems. They were rated as showing more inappropriate behaviour, were more frequently dishevelled in appearance, difficult to engage, and showed more evidence of mood elevation, suggestive of bipolar affective disorder. Observations about problems in thought form, thought content, and perception, which raised the possibility of psychotic processes, were also more frequent. They also had more orientation, and memory difficulties, and their insight was rated as being poorer.

In the comparisons between those who were psychiatrically hospitalised, and those who were not, the mental status variables of behaviour, engagement, mood, thought form, thought content, perception and orientation, were significantly different between the two groups. Again, all of these differences were in the direction of those that were hospitalised showing more frequent and severe symptomology.

The results with regards mood are also interesting. The affect of more of those who were hospitalised was rated as appropriate, and more of those who were not hospitalised, showed evidence of depression, anxiety, and anger. This is in keeping with the finding that this group also showed more evidence of suicide risk. It also reflects the fact that the legal standards of both insanity and disability focus on the cognitive and not the emotional aspects of human functioning. Disturbances of mood, however, can be very disabling for the individual. Amongst the group who was hospitalised, there was more evidence of mood elevation. This was not surprising, given that it was defined to also include mood incongruity, and lability. This finding is consistent with that reported by Rogers (1986). In this study, which was developed as part of the standardisation of the R-CARS, higher levels of elevated mood, or euphoria at the time of the crime, which the author regarded as suggestive of mania, were found in the group that were legally insane, in comparison with those who were psychiatrically evaluated, but found to be sane. This finding likely occurs because, psychosis at times occurs as part of bipolar affective disorder.

The Rogers (1986) investigation also found more evidence of hallucinations, and delusions amongst those who were insane, which is consistent with the results of the current study, and is to be expected given that they are important features of psychosis. The Rogers (1986) study, however, assessed these variables with reference to the time of the crime. In both studies, while there was more evidence of these symptoms, amongst those who received a psychiatric outcome, there was not complete discrimination between groups, and a small percentage of those found to be sane also had delusions and hallucinations. This is in keeping

with the legal constructs, in that in order to meet the criteria, not only does mental disorder need to be present, but also it must impact on certain aspects of the person's functioning.

The Rogers (1986) study also, found major impairments in self care, at the time of the crime, amongst those found to be insane. While this variable was not directly assessed in the current study, differences in ratings of dishevelment were similar, between the group who were hospitalised, and those who were not. Those that received a report however, were more dishevelled, than those who did not.

In a similar manner, while insight was significantly different between the group who received a report, and those who did not, there were no significant differences between the group of defendants who were hospitalised, and the group who were not. Rice et al. (1991) found that convicted offenders were more frequently rated as showing insight, compared to insanity acquittees.

The high degree of discrimination between groups, found on the mental status variables, helps confirm its usefulness as a valid clinical measure. It is relatively quick to administer, and yields information that is valuable in decision making.

Summary

- (1) *There were significant differences in the expected direction, between the group who received a report, and the group who did not, on all ten mental status variables.*
- (2) *There was significant discrimination between the group who were hospitalised, and the group who were not, in the ratings that were made on the mental status variables of behaviour, engagement, mood, thought form, thought content, perception, and orientation. These variables are most related to major mental disorder.*
- (3) *The mental status examination is a very useful and relatively quick screening measure.*

5.1.11 Diagnoses

It is relevant to emphasise that the diagnoses discussed in this study were extracted from the psychiatric reports completed for the courts. They were not made during the CLS assessments, which were quick screens for psychiatric symptomology, rather than the detailed assessments that are necessary to render an accurate diagnosis. The reports written for the courts do not necessarily contain diagnostic information, especially when hospitalisation is not being recommended. Clinicians, who write these reports, aim to provide advice regarding specific legal questions, and recommendations. It may be regarded as inappropriate, to include the full outcome of assessment and diagnostic formulation, particularly with regards personality disorder, which is frequently regarded as being outside the parameters of psychiatric treatment. Indeed, some scholars specifically have recommended that diagnostic information not be included in sanity reports (Golding & Roesch, 1987), or competency reports (Grisso, 1986).

Significant differences were found in the patterns of diagnoses, when the group who were eventually hospitalised, were compared with those who were not. Table 30 compares the results of the current study, with the current diagnoses, reported by Brinded, Fairley et al. (1996), for sentenced male prisoners, and with Wells et al. (1989) for the New Zealand general population. It is important that comparison between these studies be made with caution, as each study has utilised different methodologies in assessing psychiatric diagnosis, and there is some confoundment with gender. The number of defendants at this stage of the study was also small.

In the current study, primary diagnosis was coded only, and consequently it is likely that there are much higher rates of both substance abuse and dependency, and antisocial personality disorder, as secondary diagnoses, amongst both the sample who were eventually hospitalised, and those who were not. Some evidence comes from the results of the current study, with regards alcohol and or drug abuse, discussed above (chapter 5.1.8). About half of all defendants, in the

current study, acknowledged difficulties with substance abuse, however, they may not have been of sufficient severity to warrant a diagnosis. Joseph (1990) reported that of defendants referred for psychiatric evaluation at a London court, 10% were diagnosed with personality disorder, 6% with drug induced psychosis, and a low 6% with alcohol dependence.

Table 30

Percentage of diagnostic groups in various studies

Sample	Wells et al. (1989)	Brinded, Fairley et al. (1996)	Current study	
	General population	Sentenced male prisoners	Defendants not hospitalised	Defendants hospitalised
Schizophrenia	0.1	1.0	8.8	43.8
Bipolar affective disorder	0.1	2.0	6.8	17.5
Depression	3.7	6.0	12.2	1.8
Substance abuse/dependency	0.8	Drugs 38.0	27.0	0
	6.5	Alcohol 12.0		
Antisocial personality disorder	0.5	71.0	6.8	0

Slightly less than half of those who were eventually hospitalised were diagnosed with schizophrenia and 17.5% with bipolar affective disorder and an additional 14.0% were identified as being psychotic without a specific diagnosis. Table 30 shows that schizophrenia, bipolar affective disorder and depression are more common amongst sentenced prisoners than the general population, especially amongst those who have been psychiatrically assessed as defendants following referral to the CLS. Higher rates amongst those who have been assessed were to be expected, in that the manifestations of these disorders would likely have lead to requests for psychiatric evaluation. If schizophrenia is present there is a higher likelihood that a psychiatric admission will eventuate, than if bipolar affective disorder or depression are present. This probably reflects the incidence of psychosis that is associated with these disorders. Schizophrenia, bipolar affective disorder and in the same manner depression, may be present in an

individual, without them necessarily meeting the legal criteria for insanity, disability or compulsory treatment. In its most severe forms depression is accompanied by psychotic processes, which could well impact on a person's legally functional abilities, however, on most occasions when depression is assessed, the person would not meet these criteria. Joseph (1990) found that in his sample, 48% of defendants referred for evaluation were diagnosed with schizophrenia, and 11% affective psychosis. Overall, these rates are similar to those of the current study.

While the numbers involved are small, the higher rates of intellectual and organic impairment, amongst those who were not hospitalised, probably also relates to the fact that while these individuals meet the diagnostic criteria for these disorders, their difficulties were not of sufficient severity to warrant psychiatric admission. The ambiguous nature of the MHA, 92 with regards intellectual disability may also have contributed to these findings. This pattern of findings is consistent with the study by Rogers (1986), who reported that 9.7% of those who were evaluated had mild levels of mental retardation, and 4.3% of those who were found to be insane. Many people with intellectual or organic difficulties, and who commit crime, are sentenced in the usual manner by the criminal justice system. This aspect of the individuals functioning however is likely to be taken into consideration, by the judge in imposing sentence.

Summary

- (1) *Those defendants who were psychiatrically hospitalised as a consequence of their court proceedings, most often had diagnoses of schizophrenia, bipolar affective disorder, or unspecified psychosis.*
- (2) *These diagnoses, however, were also made amongst some of those who were not hospitalised.*
- (3) *Defendants, who were not hospitalised, more frequently had diagnoses of depression, substance abuse or dependency, and antisocial personality disorder.*

5.1.12 Prediction of report

Using discriminant function analysis, the combination of the variables, psychiatric history, perception, age, thought form, and thought content, were found to successfully predict the completion of a psychiatric report. In this analysis 32.4% of the variability of the discriminant function, was accounted for by between group differences. With the exception of age, the variables in the model are reflective of severe mental illness. Difficulties with perception, as coded in this study, suggest hallucinations, and difficulties with thought content, most likely reflect delusions. Hallucinations and delusions are indicative of psychotic processes, and in this analysis these were significantly interrelated. The inclusion of psychiatric history in the model is not surprising, given the enduring nature of severe mental disorder, and the fact that severe difficulties are likely to have been treated in the past. In the analysis, there was a strong correlation between psychiatric history and the completion of a psychiatric report that accounted for about 26.0% of the variance. The reasons for why being older is predictive of the completion of a psychiatric report are not clear, and have been considered above (chapter 5.1.3). The unique contribution of each variable to variance was small, which is consistent with the level of intercorrelation amongst the variables and the nature of psychotic illness. Age, however, did not correlate with the other variables, with the exception of thought content.

The function produced from this analysis was able to accurately predict 74.1% of cases, including 71.6% of those who received a psychiatric report, and 75.9% of those who did not. Its ability to predict the completion of a psychiatric report was about equal to its ability to predict the decision that a psychiatric report was not warranted. No previous study was found which attempted to predict whether a psychiatric report was completed and with which the results of the current study could be compared.

5.1.13 Prediction of hospitalisation

The series of discriminant function analyses that were completed were all able to successfully predict psychiatric hospitalisation, as an outcome of the court proceedings. When the predictor variables that were entered into the model did not include diagnoses, thought content, thought form, perception, psychiatric history, and mood were found to be able to account for 33.3% of the variability. The unique contribution to variance of each of the variables was again significant, but small. As with the analysis predicting the completion of a psychiatric report, the variables most suggestive of psychosis, thought content, thought form, and perception, were included in this function, as well as psychiatric history. Mood was also included, and correlated in a negative direction with the criterion. Significant intercorrelations were found between thought content and thought form, and between thought content and perception. Mood and psychiatric history however, did not significantly correlate with the other variables in the model.

The model produced from this analysis was able to correctly predict 59.6% of those who were subsequently hospitalised, and 90.7% accurate classification of those who were not. This yielded an overall correct classification rate of 82.8%. Most of the correct identification using this model, was of those defendants who were not hospitalised, and the accuracy of the model in predicting those who were hospitalised was much less. The overall result probably reflects the much greater number of people in the current study, who were not hospitalised.

When diagnosis was included as a predictor, the variables that best predicted psychiatric hospitalisation, were diagnoses, thought content, perception, and mood. The discriminant function was able to account for 45.1% of the between group variability. While diagnosis contributed unique variance to the model, it also correlated significantly with all other variables with the exception of mood. The correlation between diagnosis, and the criteria of psychiatric hospitalisation, accounted for about 35% of the variance.

The function produced from this analysis was able to accurately classify 85.7% of cases. This overall result is only slightly greater than the predictions made without diagnostic

information. The percentage correctly identified of those who were not hospitalised, remained at the same level, however, the percentage of those that were hospitalised, that were correctly identified increased to 71.2%. This implies that diagnoses contributes relatively little to the prediction of those who are not hospitalised, however, it is important in predicting those that are hospitalised. This is not surprising, in that the way the assessment process functions is that gradually more refined diagnostic information is sought, which may indicate that psychiatric hospitalisation is warranted.

The addition of diagnostic information into the predictive analysis, resulted in an improvement in the classification of those who were hospitalised that was statistically nonsignificant. However, from a clinical perspective, there was correct identification of six additional cases, and for the individuals involved and their families this would very likely be important.

The variable of diagnosis, alone, was able to predict outcome at the same degree of efficiency, as the combination of variables. In the predictions using all variables, the independent contributions to variance were statistically significant, yet were very small. When the predictions were translated into correctly classified cases, variables other than diagnosis had minimal impact. The most likely explanation of this is that diagnosis, is best thought of as a higher order construct, than mental status or psychiatric history. Diagnosis is based on this type of information. Nevertheless, in the absence of diagnostic information, other variables are able to make good predictions especially about those who do not require hospitalisation.

There are three other studies, available in the literature, which have employed discriminant function analysis, with which to compare the results of the current study. In all the studies discussed below, the predictor variables were assessed during psychiatric evaluation, which contrasts with the current study, in that, with the exception of diagnoses this information was collected prior to this stage, at the time of the CLS screening. The other studies also, did not include the detailed mental status information that was entered into the predictive equation in the

current study. Overall, however, the results of the current study are remarkably consistent with the findings in other jurisdictions.

In their Canadian study, Rice and Harris (1990), examined the variables that discriminated between a group of insanity acquittees, and a group who had been psychiatrically evaluated, but found to have no defence. In this study, the most important discriminating variable was index offence. The addition of a range of variables, including demographic and clinical information, only yielded a small nonsignificant increase. No combination of variables could improve on the predictive accuracy, of simply predicting that all evaluatees charged with murder or attempted murder, would be found not guilty by reason of insanity, and that all those charged with any other offence would be convicted. Predictions of this nature yielded a correct classification rate of 82%.

Comparing insanity acquittees with a group who had been evaluated and were matched on index offence, thus controlling for index offence, the most important discriminating variable was DSM-III diagnosis. A dichotomisation of diagnosis, psychotic or not, was correlated with the criterion (.63) and yielded 81% correct classifications. As with the result reported above, no combination of study variables, yielded a significant improvement diagnosis alone.

The current study, found no association between the nature of the index offence, and outcome, which is consistent with the findings of Callahan et al. (1991) and Bogerberger et al. (1987). A likely explanation for this, is that the nature of the legal standards, and their interpretation, or the way the criminal justice system operates in Canada, where the Rice and Harris study was conducted, somehow produces a greater likelihood of those charged with murder or attempted murder, being found not guilty by reason of insanity. While the current study translated diagnosis into a scale, rather than a dichotomy, and the criterion group was mixed with regard to legal status, the correlation of diagnosis with the criterion was similar (.59). In the current study, diagnosis, together with thought content, perception, and mood, yielded a very similar, 82.8% correct classification of cases.

Hart and Hare (1992), in another Canadian study, investigated the relative power of demographic, criminal, and clinical variables, to predict the criteria of fitness to stand trial. In a sophisticated design, diagnoses were made for research purposes, rather than clinical or legal purposes, and were made blind with respect to outcome. In this study the presence of psychosis correlated at a level of .42 with the criterion. Again it was found, that diagnostic variables discriminated best between fit and unfit subjects, and that multivariate combinations of demographic, criminal and other clinical variables could not improve over the predictive efficiency of diagnostic variables, either alone or in combination. The variable of any psychotic disorder could accurately predict 54% of those found to be unfit, and 88% of those found to be fit to stand trial. This result was interpreted as reflecting the valid and useful role of mental health experts in the forensic area.

Nicholson and Johnson (1991) investigated the prediction of competency to stand trial, using a similar variety of variables, and including measures of psycholegal ability. In this study, predictive efficiency was maximised, using a combination of all seven predictor variables (age, gender, race, and type of offence, WAIS-R IQ, GCCT score, and the presence of psychosis). Together they accounted for 19% of the variance in competency status, which compares with the 45% found in the current study. The correct classification of cases using the model, produced in this analysis was 78%, which is slightly lower than that reported in other studies, and the 86% found in the current study. Performance on the GCCT and psychosis, were predictive of competency decisions, even after controlling for the remaining variables. The correlation between the presence of psychosis and the criterion, found in the Nicholson and Johnson (1991) study was .26, which is notably lower than the other studies, and may explain the differences in findings.

Given the nature of the legal standards, it is not to be expected that any statistical model based on demographic, background, and mental status, such as was employed in the current study, should be able to totally accurately predict outcome. While the presence of psychosis, played a major role in decisions that a person be hospitalised, rather than receive criminal

sanctions, other variables were also involved. It is not simply a screen that results in psychotic defendants being hospitalised. For the insanity defence to succeed 'natural imbecility or disease of the mind', must have an impact on the person's ability to understand the 'nature and quality' of the act, or that it was 'morally' (see chapter 1.2.4). The impact of psychotic thinking must have occurred at the time of the crime, rather than at any other time, for example, the time of the assessment. For a finding a disability, it must be shown that mental disorder impacts on abilities than are functionally relevant at court.

The other issue that is relevant to revisit is that there is no external validation of the constructs of insanity and disability, and given their very nature this is not possible. These constructs are based on social and moral judgements, and because of this are not absolute. The criteria, used in the current study, reflects the decisions made by judges, on the recommendations of psychiatrists. It is possible that these are not perfect decisions, and that biases and errors of some kind, may have occurred in this decision making. Factors such as the current political situation, and other variables beyond the circumstances of the individual defendant, may have influenced outcome.

Summary

- (1) *A combination of mental status variables and psychiatric history was able to successfully predict an outcome of hospitalisation.*
- (2) *The addition of psychosis, as a predictor variable, resulted in an improvement in the correct prediction rates of those that were hospitalised, but not those who were not hospitalised.*
- (3) *Diagnosis, alone, was able to predict outcome, as efficiently as a combination of variables. This is likely because it is a higher order construct, than subsumes much of the other information. International studies also have found that diagnostic information is predictive of outcome.*
- (4) *The predictive efficiency of the model was comparable with other studies.*

5.2 IMPLICATIONS

5.2.1 The Court Liaison Service

The current study confirms the usefulness of the CLS and the screening assessments completed by the nurse at court. There is little doubt, that the role the CLS plays at the interface of the criminal justice and mental health systems, is a crucial one, and that the development of the CLS, has led to increased numbers of appropriate referrals, and fewer inappropriate referrals for psychiatric evaluation and report. Appropriate referrals appear to be those where there is evidence of psychotic processes that can be treated by medication, rather than degree of distress or impairment in functioning.

While CLS personnel are involved in the decision making, with regards to which defendants receive reports, they also provide a wealth of other mental health related information to the courts, in both an informal and formal manner. At court they are clearly identified, as the people who deal with mental health related queries. They are easily accessible, which implies that mental health related information might be more readily sought, because of the ease of access to this resource. The CLS provides an educative role in teaching people, within the courtroom about mental health issues, as they apply to criminal defendants generally, or in specific cases. CLS staff make referrals of defendants, to a variety of agencies involved in mental health, regardless of the outcome of the legal proceedings, and therefore help ensure that there is exchange of relevant information, thus reducing repeat assessments by various agencies, and quick placement in appropriate treatment programmes. It is likely that as Brinded, Malcolm et al. (1996) have pointed out, the presence of CLS personnel in court has led to reduction in time delays in legal proceedings when psychiatric issues are considered. This likelihood has not however, been empirically investigated in New Zealand. There is also a role played in terms of helping the RFPS provide an efficient service to the courts, in ensuring the smooth running of the interchange between the criminal justice and mental health systems.

The lack of significant differences in the demographic characteristics between those who received a report and those who did not, and between those who were hospitalised and those who were not, is theoretically consistent with the constructs of insanity and disability. There is no reason why demographic characteristics should influence decision making of this nature. While no evidence was found of any overt biases, when the results were compared with other New Zealand studies, there was a suggestion that defendants of Maori descent and females require careful assessment.

The eventual outcome of the court proceedings can be predicted, from the information assessed at the time of the CL screening. This was especially so, for those that were not hospitalised. The addition of diagnostic information did not significantly increase the efficiency of the predictions. This suggests that a greater role might be played by CLS staff, in the decision making about recommendations to the court, about who gets hospitalised.

5.2.2 The vulnerable

The results of the current study indicate that those defendants who receive psychiatric evaluation, but who do not meet the criteria for hospitalisation are a particularly vulnerable group in that they have a number of indicators of lack of mental health and risk. They have criminally offended, and are held responsible for their illegal behaviour, which is disapproved of by society, but they remain vulnerable in terms of their mental health needs. In the current study, in comparison with those who were hospitalised, the behaviour of those who were not hospitalised was rated more frequently as dysphoric, and they showed more evidence of depressed mood. They also had significantly higher rates of family conflict, substance abuse, suicide history, and risk, and were more frequently referred because of concerns about dangerousness. The findings of the study by Holley et al. (1995) are relevant, in that prior court ordered forensic assessment was associated with suicidality, amongst a sample of remanded offenders. While it is probable that some in this group receive psychiatric or psychological assistance, either in prison or in the

community, as a result of the conditions sentences such as supervision, the issue can be raised, as to whether more can be done to assist this group, in terms of their vulnerable mental health status.

When a person is referred for psychiatric evaluation, and does not meet the criteria for admission, yet presents with substantial risk of suicide or dangerousness, it is most probable that either the assessor or CLN, will contact the medical staff at the prison, and alert them to this risk. It is recommended that this be formalised. The results of mental health assessments could be routinely held on prison files, to enable the ready placement of offenders within treatment programmes. While the primary aim of current forensic psychiatric evaluations, on criminal defendants, is whether they meet the legal criteria for insanity, disability, section 118 CJA, 1985 hospital orders, or compulsory assessment and treatment, reports particularly on those for whom psychiatric hospitalisation is not recommended, could well include suggestions for the management of mental health issues. This might include delineation with regards important individual parameters to be observed, for example, level of depression or suicidality, as reflected in behaviour.

It would also be valuable to standardise the assessments tools that are used both by the CLS, and within the prisons to assess suicide risk, in order that the CLS ratings could be used as a baseline for comparison whilst the person is in prison. The Beck hopelessness scale has been empirically shown to be a valid measure of suicide (Beck, Steer, Kovacs, & Garrison, 1985), and would be suitable for this purpose.

It is notable that many of the difficulties shown by people in this group are internalised, and frequently not readily apparent. This is in contrast with externalised difficulties, such as florid schizophrenia, which tend to be obvious and are less easily missed. This implies that careful ongoing assessment and observation is necessary.

Researchers such as Freeman and Roesch (1989), have also drawn attention to the largely unstudied group of people who, while having significant mental health problems, do not meet the legal criteria for diversion to the mental health system, and are treated simply as

criminals. Teplin (1991), in discussing the criminalisation hypothesis, argued that the closure or down sizing of large state mental health hospitals, has resulted in the increasing presence of the mentally ill within the criminal justice systems. Both patients who have been deinstitutionalised, and emerging numbers of young people, with an early history of mental illness without treatment, and substantial substance abuse difficulties, are detected by the criminal justice system. Poverty, unemployment, homelessness, criminal victimisation, and criminal incarceration mark their lives, and because of the inadequacies of mental health services they become criminalised. Most of these people are diagnosable, within frameworks such as the DSM or ICD, yet they are found to be legally sane and fit to stand trial.

In her Californian study, Teplin (1985) found that mentally ill people were most likely to come into contact with the police, essentially because they needed assistance with regards to things such as food or shelter, and not because of serious criminal offending. She found also, that the police were unfamiliar with dealing with mental illness and often failed to identify it. Arrest was often preferred, over the more cumbersome process of obtaining intervention in the mental health services. While Teplin (1991) acknowledged some inconsistencies in the empirical support for the criminalisation hypothesis, and generalisation to New Zealand is unknown, the hypothesis does draw attention to a possible consequence of large scale change in the delivery of mental health services. By implication, it might be expected that the number of insanity acquittees, those under disability and those who receive hospital orders as a consequence of an appearance in the criminal courts, should increase. However this is not necessarily so. Hospital economies are such that there are only a limited numbers of beds for forensic patients available. With increasing pressure on bed numbers, there may well be a subtle alteration in the threshold for the determination of mental disorder, or psychiatric admission. Rather than the number of insanity acquittees, and other hospital orders increasing, there might be increasing numbers of those who have significant mental health difficulties yet are not hospitalised and are imprisoned.

The current study has confirmed the existence of a very vulnerable group, who has significant mental health difficulties yet are not hospitalised. It has not however, produced any evidence to indicate that the difficulties of this group, are any more or less than prior to the downscaling of psychiatric hospitals in New Zealand, and no conclusive statement can be made in this respect. It does emphasise however, the importance of research projects monitoring any change in the degree and severity of psychopathology, in its widest sense, within this group over time.

5.2.3 Insanity

The findings of this study raise the question as to the extent to which assessments with regards to insanity are a truly useful part of the work of forensic mental health professionals. The number of people that eventually receive these dispositions is very small, and forensic psychiatric and psychological assessments concentrate on these issues, which involve considerable resources. It can be argued that all people should be viewed as responsible for their criminal behaviour, and that paternalistic notions of the protection of the severely mentally ill, even if they criminally offend, should be abandoned until it was empirically demonstrated that sentencing does not work. Scholars such as Halpern (1991), who have advocated for the abolition of the insanity defence, have stated that rather than it being essential to the moral integrity of the law, in fact it makes a mockery of the criminal justice system, and enables unfair and inconsistent practices to continue.

The arguments put forward by Monahan (1973) are also relevant. He proposed that the insanity defence could be justified only under two circumstances. The first of these, which is empirically supported, is if belief in responsibility for one's actions can have an effect on behaviour. The second is whether the existence of the insanity defence, contributes to an individual's belief in personal responsibility. There is very little empirical support, in either direction to this question. Monahan (1973) concluded that there is little logical or empirical support for the continuing existence of the insanity defence, from the perspective of the ordinary citizen. The legal system, however, given that it is based on the concept of free will, requires the

insanity defence to function adequately. He did not recommend the abolishment of the insanity defence, because of concerns both about the complete acquittal of increasing numbers of mentally disordered offenders, and because it would reduce any treatment focus present within the present criminal justice system.

If the insanity defence was abolished, determination of mens rea and therefore culpability could occur however, without considerations of whether the person met the legal standards for insanity, and these decisions could still be informed by mental health professionals. Defendants who lacked the state of mind required as an element of an offence would be acquitted outright, and in a separate transaction, assessment made as to whether compulsory assessment and treatment was indicated. The legal mechanisms currently existing, under section 45 of the MHA, 1992 also provide for the transfer to psychiatric hospitals of any imprisoned offender, who has a mental disorder. A likely implication is that there would be an increased use of these provisions. Section 46 of the MHA, 1992 enables transfer, if the Secretary of Justice believes that the person would benefit from psychiatric care, that is not available in prison, whether or not they are mentally disordered, and if the person consents. The flavour of this option is reflective of treatability, regardless of whether the person meets the legal criteria of mental disorder.

It may well be more useful for psychiatric and psychological assessments, which result from a person's appearance in court to instead concentrate on the issue of whether the person meets the criteria for compulsory admission to hospital, under the MHA, 1992. Admission criteria for mentally disordered offenders could also be further developed, with reference to the probability of treatment success within the mental health system, rather than the current criteria which are imposed by the historical weight of the legal system. Authors such as Morris (1982) have argued that the constructs of competency to stand trial, and legal insanity, are ineffective ways of identifying who require treatment by mental health services. Psychiatric admission could be dependent on whether mental health treatment could, either potentially benefit the individual, or contribute to a reduction in the likelihood of recidivism. Under these criteria, civil rights and

the issue of the person's consent becomes relevant, in that while treatment aimed at reducing recidivism, might be a justifiable response to criminal offending, it is doubtful whether a judgement that treatment would be in the person's interest would be a sufficient justification for the imposition of unwanted treatment. The options however, could be made available, and sentencing could take regard of the person's willingness to improve him or her self, by therapeutic means. The concept of treatability also has relevance, in that, it is questionable as to whether there is any point in admitting a person to a psychiatric hospital, unless effective treatment for their mental health problem is available, regardless of their mental health status at the time of the crime.

In some American jurisdictions, diversion to the mental health system is dependent on the person meeting the criteria of being suitable for treatment (Heilbrun, Bennett, Evans, Offutt, Reiff, & White, 1992) and these might potentially be explored in order to avoid any pitfalls. The issues of making valid, and reliable assessments, is relevant to decision making of this nature, and it would be useful for research endeavours to address these matters with the aim of ensuring fair and rational decision making. Heilbrun et al (1992) produced evidence indicating that moderate levels of reliability could be met, when treatability was carefully defined, under controlled conditions, and was done by raters who have extensive clinical and historical data on which to base their judgements. In an earlier study, Heilbrun, Bennett, Evans, Offutt, Reiff, and White (1988) described marked variability in the assessment of treatability. An exception to this was the high level of agreement amongst clinicians that psychotic symptoms are effectively treated with psychotropic medication.

If assessments were focused on the issues of treatment, there may well be development in the area of the specification of treatment goals, and the means by which it is anticipated that these goals might be met. The focus would become more individualised, and it would foster the development of effective treatment programmes, with a focus on empirical evaluation. Following the achievement of treatment goals, the person could resume a prison sentence. Treatment

against a person's will, could not be imposed for any period of time longer than that for which the person was sentenced.

Decisions related to the release of a person from confinement, either in prison or in hospital, would be uniformly made by the sentencing judge, with reference to the original criminal behaviour and sentencing principles, and would be unrelated to improvement in mental status. Indeterminate containment, such as is currently a possibility for those found not guilty on the basis of insanity, would not be an option. Responsible clinicians would be relieved of decision making with regards to how long to keep relatively well functioning individuals in hospital, for essentially political reasons. Social control would more clearly come under the province of the criminal justice system, and clinical assessment and treatment the sole focus of the mental health system. This would involve the relinquishing of power by many mental health professionals.

Currently within the criminal justice system, once a person's sentence is served, he or she can not be further detained on the basis of concerns about the risk of future dangerous behaviour. Within the mental health system however, concerns of this nature provide a justification for ongoing confinement. Within the criminal justice system sentences are always finite, however within the mental health system, they are made on the basis of probabilities. This is anomalous, and conceptually problematic, especially in that people with the most likelihood of committing dangerous behaviour including reoffending, are to be found amongst those with psychopathic characteristics, and typically these individuals are detained within the criminal justice system. If the insanity defence was abolished, and all individuals given a finite sentence, this differential situation would not occur. Alternatively, society could clearly decide that regardless of whether a person was contained within the criminal justice or mental health system, a high probability of future dangerous behaviour, could provide sufficient justification for ongoing containment.

Mental health professionals would have more resources to put into the clinical assessment and treatment of individuals, either in the community or in hospital, and the development of these skills. This would seem to particularly apply to the at risk group identified

in the current study, of those who were assessed, but did not meet the criteria for psychiatric admission, and have been described as vulnerable. These people appear to have significant mental health problems and the extent to which they are fully treated within either the prison, or by hospital transfer is questionable. Abolishing the insanity defence in New Zealand would lead to a much simpler and fairer method of dealing with mentally disordered offenders. It would alter the focus of the involvement of forensic mental health professionals away from complex decisions about legal standards towards effective assessment and treatment methods. It would provide for a structure that is itself, much saner.

In a similar manner it is also recommended that section 118 CJA, 1985 hospital orders, also be reviewed. It would be consistent with the abolishment of the insanity defence to also abolish this option. This would eliminate the inherent confusion with regards its punitive or therapeutic aims. The usual practices of sentencing could occur, with the possibilities of compulsory treatment and transfer to psychiatric hospital from prison if indicated. McElrea (1992) proposed that prison sentences be suspended while a person is subject to a compulsory treatment order. However whether prison sentences should be suspended until a later date or crime incident, or run concurrently with compulsory treatment orders, requires further debate.

5.2.4 Disability

While it is recommended that the insanity defence, and orders under section 118 CJA, 1985 be abolished, it is proposed that the concepts underlying disability are of fundamental importance in ensuring a fair trial, and should be retained. Defendants must be able to have at least minimal understanding of the legal process. Consideration should be given to the introduction of some form of trial of facts, or testing of the actus rea component of the case. It is somewhat contradictory, that the law is protecting the right of these defendants to a fair trial, yet it is not necessarily, in the person's best interests, to be found unfit to stand trial, and to be detained in a psychiatric hospital possibly, for long periods, without any proof that they did commit the behaviour under question, or any demonstration of sufficient evidence for criminal

prosecution. A provisional trial, would also allow direct assessment of the defendant's abilities, in the criterion situation, and would provide useful data with regards the validity of any assessment methods.

Also of relevance, is what occurs to those who are found to be under disability. Unless there is evidence of psychosis, it is not suitable for these people to be confined in a psychiatric hospital. Hospitalisation is not justified for defendants who are found to be intellectually disabled or organically impaired. It is associated with unnecessary social stigma, and institutionalisation can result in a loss of effective living skills. The development of separate facilities, for this small but very important group of people is warranted. New Zealand law allows for the return of those found to be under disability, to be returned to court to have the case reheard, once the persons mental status has been 'restored'(s. 116 CJA, 1985). This facility could focus on the development of skills in the comprehension of the legal process, and provide treatment programmes aimed specifically at meeting this goal. Roesch et al. (1993) outlined three issues for consideration in the development of treatment modalities for lack of fitness to plead. The first of these was the delineation of expected level of competency, so that specific behaviours could be targeted. Little is known about the average criminal defendant in terms of what abilities and knowledge they have that the person under disability is regarded not to have. Secondly they questioned whether it is possible to predict who may be responsive to treatment, and thirdly whether it is possible to provide treatment in the community rather than in hospital.

There are a few examples in the literature of treatment programmes in this area. Siegal and Elwork (1990) standardised a treatment procedure, aimed at restoring competency to stand trial, and to empirically demonstrate its efficacy. The treatment was used as a supplement to traditional treatment methods involving medication, and subjects were randomly assigned to groups. Instruction, videotapes, modelling, and problem solving sessions were used to teach defendants courtroom procedures, communication with legal representatives, the roles of various legal personnel, and to evaluate the consequences of various legal actions. When compared with

a control group, who received the standard treatment, these sessions were shown to be more effective in helping a greater number of defendants, become competent to stand trial. Davis (1985) described a treatment programme, in which a plan was developed for each defendant that addressed the areas of: knowledge of charges and possible consequences; ability to communicate rationally with attorney; knowledge of courtroom procedures; and the capacity to apply knowledge to the demands of the specific legal situation. Treatment which included mock trials, took place in a group setting, yet it was individualised and addressed the particular features that make an individual unfit to plead. No information was available with regards the effectiveness of this programme.

5.2.5 Victims

While the Victims of Offences Act, 1987, introduced the provision that judges consider a victim impact statement in sentencing, the extent that this occurs in the cases of mentally disordered offenders who are disposed of by the court remains largely unknown, undebated, and unclear. Despite the legal reference under section 115 CJA, 1985, to consider public protection in deciding the disposition of those found to be insane at the time of the crime, or under disability, there is no requirement to specifically consider the individual victim, as has been recommended by the Victims Task Force (1993). Also, while the Victims of Offences Act, 1987, directs authorities to inform victims when offenders are released, or escape from custody, there is no requirement for this to occur when a mentally disordered offender is discharged into the community, or he or she escapes. The recommendations of Victims Task Force (1993), for the inclusion of those held in psychiatric hospitals, as a consequence of unlawful behaviour, under these provisions have been unheeded in New Zealand, but there is no good reason why this inequity should continue to occur.

The abolishment of the insanity defence, would mean that at least the same minimal regard that is paid to the victims of those who are criminally convicted, would also apply to those who are mentally disordered. The question of the abolishment of the insanity defence, and section

118 CJA, 1985 hospital orders, requires public debate and discussion, prior to final decision making and a considerable length of time would be necessary for this to occur. Changes such as those proposed by the Victims Task Force (1993), with reference to improving the recognition of the victims of mentally disordered offenders could and should be enacted as soon as possible.

5.3 CRITICISMS OF THE CURRENT STUDY

While the results of the current study are overall consistent with the other New Zealand CLS studies, it is important to note that one nurse did most of the screenings at court and initial data collection. This raises the question of the extent of inter rater reliability. It is unknown whether personality or other individual characteristics in any way influenced the nature and type of information that was disclosed by defendants, assessed or recorded. The use of predetermined assessment schedules and agreed formats would reduce the possibility of considerable variations between different nurses, however this study did not directly address this issue. The extent of inter-rater reliability in the data collection could have been examined by requesting a number of nurses to screen a group of defendants and comparing their results.

A related issue is the extent of generalisability of the findings to other New Zealand locations. There may be specific characteristics of the Christchurch sample such that the results of the current study do not hold in other locations. Of relevance is the uneven distribution of Maori people and subsequently young people, that is found in New Zealand.

In extracting data for the current study, from the CLN's files, two main difficulties, insufficient information and inconsistent data collection, were identified. While these issues are relevant, in the use of data for research purposes, they do not necessarily apply to the clinical use of the information. For some variables insufficient information was collected. For example, there were not enough details of the alleged crime recorded to enable coding with reference to the seriousness of the crime. Study of crime type with reference to the most serious charge only, as was used in the current study, yields relatively little information about the range and severity of the criminal behaviours. The category of violent crime included acts ranging in severity from murder to threatening to kill. Sexual offences included sexual violation and obscene exposure. Both the person who faced charges relating to more than fifty counts of false pretences, and the defendant who stole a tube of glue, were rated as having committed property crimes. Lack of information with regards the nature of both the alleged offending, and forensic history, and the

subsequent coding of crime type, may have accounted for the lack of significant findings with regards to the variable of crime in the current study. It is not possible to conclusively state that the alleged offending was of no relevance in determining subsequent outcome.

Of the variables that were categorised at the time of the assessment, some did not include sufficient categories, to accurately reflect the situation of many defendants. Relationship status, for example, did not include a category referring to defacto relationships. People, who lived with their partners without legally being married, might have been coded as either married or single. In others areas there was inconsistency, in the information gathered. For example, data collected under the heading 'accommodation', referred to either housing arrangements and the people whom the defendant was living with, or both.

In the current study, some of the data collected was prospectively coded at the time of the assessment, and some was retrospectively coded. The retrospective nature of the coding of some variables may have introduced a source of error that could potentially have been minimised. Because some information was retrospectively collected, sufficient information for research purposes was sometimes not available. The variable of diagnosis was extracted from court reports, yet it is not a direct purpose of these reports to provide a diagnosis however, this information frequently is included. Many variables in the current study were coded on the basis of narrative information, and there was no guarantee that an area had been probed. With the assessment format of a structured interview, as was employed during the CLS screenings, the extent of prompts and questioning is unclear. A rating of no evidence of family support, might refer either to the fact that the person self rated his or her family support as limited, or a judgement was made that this was so. Other possibilities include lack of questioning in this area, and failure to record this information.

In the description of the sample, and in the comparisons between groups historical information such as age, and criminal history, was considered only once, whereas information that altered on each presentation, such as the mental status variables, were recorded for each

presentation. In the discriminant functional analyses, information relating to a defendant was coded with reference to the most recent presentation, and it is possible that this method loses some potentially useful information.

Collecting information in a categorical fashion, such as has been employed in the current study has the drawback of implying that information is distinctly different in each category. Some of the variables assessed might be best conceptualised as continuums, for example, depressed mood. A further issue, is the extent to which categories are mutually exclusive. It is likely that some people in this study felt depressed, as well as anxious or angry, or showed more than one sign of unusual behaviour. Behaviour and emotional state clearly overlapped. The coding of the most prominent or obvious feature, as occurred in the current study does not necessarily mean that it was the most important. Similarly there might have been more than one reason for referral, or possibly more than one referral agent.

In the current study a large number of chi squared analyses were conducted. The large number introduces the possibility that any one finding might have been due to chance.

It was unfortunate that recoding of the variables used in the discriminant function analysis was necessary, in order that they were coded on ordinal dimensions, as is necessary for multivariate statistical analyses. It may have introduced a source of error, that might have been minimised if the variables had been coded in this manner initially. The necessity of ordinal ratings for statistical purposes is conceptually difficult with regard variables, such as diagnosis. Diagnoses based on the currently available classificatory systems are categorical in nature, and it is somewhat artificial to force them into continuous ratings. It would possibly have been an improvement, to focus on a dichotomous rating of the presence or absence of psychosis.

The legal standard of insanity refers to at the time of the crime. The current study did not attempt to control for this issue. A defendant was rated as having a diagnosis of psychosis, if this was apparent during the assessment, regardless of whether it was at the time of the crime, or

at the time of the assessment. It is possible that for some defendants that their mental status may have changed over time.

The current study focused on psychiatric hospitalisation. It may have been an improvement, to concentrate on a broader conceptualisation of treatment, regardless of the setting in which it occurred. Defendants who had their charges withdrawn, and commenced some form of community intervention, were categorised in the justice group, despite the fact that they received some form of mental health intervention.

There is also an issue relating to the use of Bayesian statistics in clinical situations, such as was the focus of the current study. They involve comparisons with chance, which it can be argued are inappropriate, in that it is unlikely, that decision making, such as occurred in the current study, could possibly occur by chance alone. What is more important is the extent to which variables improved the predictions that were made. In the current study, the addition of psychosis, into the predictive equation yielded an improvement that was statistically nonsignificant, yet six cases more were correctly identified. Clinically and personally, this number is important.

The results of the current study refer to the years 1992 to 1994, and it is possible that there may have been some change or improvement in practices, since that time. While this is possible, any alteration would have been relatively small, and the overall results most likely reflect the current situation.

5.4 FUTURE RESEARCH

5.4.1 Court liaison research

Research into the CLS in New Zealand, would benefit from regional standardisation of the information collected at the time of the screening assessment, and the establishment of a national data base. This would enable more direct comparison between regions, and provide sufficiently large numbers, to enable more detailed study into special groups of defendants, such as those found not guilty by reason of insanity, or those under disability. While a standardised questionnaire, would yield more consistent data for research purposes, the structured interview has a flexibility that makes it particularly suitable for clinical use, and as it is adequate for research purposes, it is recommended as the assessment format that is most suitable for CL screenings. Structured interviews can include the standardised collection of some core areas of information, and this can be supplemented by additional clinical information, and possibly areas of information that might be of relevance or interest in a particular region.

Consideration might be made of using the categories employed by other researchers, or to jointly developing and operationalising variables that are frequently used in New Zealand research, particularly demographic variables, and crime related information. Ministry of Justice studies have emphasised the importance of the self identification of ethnicity, because of the error introduced by recorder judgement (Lash, 1996), and it would be useful for all CL screenings to use this method. The method of coding ethnicity used in the general population census includes various combinations of ethnic background, and the classification proposed by the Department of Statistics (1993) summarises these. It would be valuable for CL screenings to also use this system. Scales such as that developed by Spier (1996) for measuring offence seriousness, and the Beck hopelessness scale (Beck et al., 1985) could also be included in the screening protocols. Standardisation of this nature would help ensure that sufficiently detailed information in all areas is collected at the time of the screening interview, and that there is not confusion with regards the

type of information being collected. There would be increased consistency, in the questions asked of defendants, and it would enable the prospective coding of information.

To develop a national database of CL screening information, consultation and agreement amongst practitioners, and researchers would be necessary, in order to decide the core variables that would be assessed, the extent of assessment, and information required, and the manner in which they would be categorised. The collection of information for a data base, such as this would require ongoing commitment and precision, and it would be vital that it be viewed as at least as important as the clinical aspects of work. The importance of the research potential of these screening assessments may well require encouragement by management.

Consensus would also be required with regards to methods of recording information pertaining to defendants who have more than one court appearance, and present to the CLS on more than one occasion. Any revision of the manner in which data is collected should be informed of the necessity of ordinal data collection, if it is an intention, or even a possibility, that multivariate statistics might be used in the analyses.

A national data base would pave the way toward the collection of individualised, longitudinal information over time. This would enable follow-up to be made, as to the consequences of entry to either the criminal justice or mental health system. While there are privacy issues, from a research perspective there would preferably be integration between the criminal justice and mental health systems, so that there was easy tracking with regards factors such as recidivism, amongst those discharged from the mental health service. If a national data base of this nature was established, the impact of any social change could be monitored, and evaluated in a rational manner, rather than developing in a chaotic manner based on personal beliefs, preferences, biases, and persuasiveness.

It may be useful to consider inclusion of further detail in areas, such as victim information, family situation, and criminal history, and it is recommended that more of the informal aspects of the role of the CLS, such as advice giving, discussion, and follow up, be more

fully acknowledged by their systematic recording. Consideration might be also made, as to whether and how to focus more fully on people's strengths, and adaptive functioning as well as areas of difficulties. Most of the information reviewed tends to be negative, and informs only minimally about the individual's strong points. There may well be protective factors, such as strong social support, self efficacy, or some form of resiliency that relates to an absence of psychopathology.

While it would be useful to have available information such as diagnoses, ratings of psychopathy, and intellectual functioning, judgements with regards these variables require detailed information that could not be achieved in a short screening assessment. Other areas that might be useful to explore, such as history or trauma, would also be unfeasible to include, given the nature of the screen, and the fact that it would be unrealistic and insensitive to expect defendants to disclose this information over the time period involved.

The results of this study raise the question of the extent to which dangerousness is assessed during CL screenings, and further discussion of this is warranted. Information is routinely collected about suicide history and risk, however, it is not clear whether risk of harm to other people is assessed, and this information was not recorded. Dangerousness is not necessary for a finding of either insanity, or disability, yet it is frequently considered in psychiatric assessments, and is very much of community concern. A considerable number of defendants were referred for this reason, and when reason for referral was considered, significantly more of those in the group who were not hospitalised, were referred for this reason. Consideration might be made as to whether routine questioning in this area is warranted and, also the purposes that this would fulfil, given that unless it is accompanied by mental illness, it is not a justification for psychiatric hospitalisation.

Because the CLS is a pivotal point in the entry process to the mental health system, for criminal defendants, referrals to this service warrant further study. Initial referral plays a role in the potential definition and social construction of defendants as insane, or mentally disordered. It

would be useful to explore more completely, the reasons for referral, and the features of the individual's presentation, or crime circumstance, that raised this possibility. This might include the study of those for whom referral was considered, but decided against. Referral agents could be interviewed, or asked to complete a questionnaire, and vignettes reflecting various mental health issues might be provided.

Referral agents also, such as judges, legal counsel, police officers, and probation officers could be surveyed, with regard ways of improving the CLS. This might include things like whether they knew of its existence, to what extent was it easy to refer defendants, and how satisfied they were with the outcome. The focus of this type of study should be on the improvement of service delivery and not evaluation, as in some cases it is legitimate and commendable for the CLN to disagree with referral agents. It might be useful to explore the extent to which defendants themselves and their families know about, and have easy access to the CLS.

5.4.2 Victims

Further research could usefully address both the victims perspective, and the relationship between the offender, whether mentally disordered or not, and the victim. The results of the current study suggest that there may well be some distinctive characteristics, about the crime committed by those with major mental disorders, in terms of their relationships with victims, and this finding requires replication and extension. The criminal behaviour, demographic, and risk characteristics of samples of convicted offenders and those found to be legally insane, or under disability, could be matched. Exploration could then be made of this issue made with reference to summary of facts compiled by the police. Study of the victim's perspective, in this manner, would help further elucidate the etiology and processes involved in the breaking of criminal laws by both mentally disordered offenders, and those held responsible for their actions.

Research could also attend to the issue of what victims require, in order to effectively resolve the experience, when the offender is found to be mentally disordered, especially with

regards such matters as dealing with the fear of mental illness, as well as that of crime, and addressing concerns about the realistic risk of reoffending.

5.4.3 Intellectual disability

Given that it is proposed that victims hold an unheard voice, in considerations of mentally disordered offenders, it is proposed that intellectually disabled offenders fall within the cracks of the mental health, criminal justice interface.

Above (chapter 5.2.4), it was proposed that treatment methods to restore fitness to plead be investigated, the question can also be asked, as to whether interventions might be developed to improve the comprehension of those who are not under disability? This would apply to many defendants with borderline or mildly disabled intellectual functioning, as well as possibly some of those within the average range. It is likely that some emotional states such as anxiety or anger, temporarily reduce the ability of defendants to comprehend criminal proceedings. It is also possible that defendants who are involved in maintaining cognitive distortions relating to their criminal offending, have less ability to understand what is occurring, than they do at other times. While these defendants do not meet the criteria for disability, there may well be methods such as behavioural rehearsal, or assertion training, that would assist in ensuring that their participation and understanding, was as close to optimal as possible. It would be valuable to more fully investigate the understanding of all defendants of the court process, and to assess the perception of their family and friends. Possible intervention methods could be developed, and their usefulness assessed by comparing ratings of comprehension amongst defendants who used these methods, and those that did not.

5.4.4 The vulnerable

Further research is proposed of the group of defendants, who are described in the current study as the vulnerable, those who have indications of lack of mental health that is regarded as not warranting hospitalisation. It would be useful to know about how this group functions over time, and whether their difficulties resolve or not. The current study found that this group was assessed

as being at considerable risk of suicide, however whether these ratings predict actual suicide is unknown. The extent to which this group receives effective assistance with their difficulties, such as alcohol and drug treatment, is also unknown. It may be that the provision of increased or more effective treatments and interventions for this group may well reduce their risk of reoffending, and suicide attempts, and assist their personal well being.

Ongoing research and theoretical development is also necessary into core issues such as the etiology of crime. Early intervention for those at risk, in terms of their mental health needs may effectively assist in the prevention of crime. Further study of this group will also assist in the understanding of where and why, threshold decisions are made between offending for which individuals are held responsible, and offending for which individuals are not culpable.

5.4.5 Treatment

While the treatment of those who enter the mental health system, via the courts was not directly studied in the current project, it is of relevance to consider in future research, in that there is likely to be some interaction between treatment efficacy, and eventual community success. Indeed it would be valuable for further research to confirm and clarify this hypothesis.

There is only limited information available with regards effective treatment modalities, for defendants who are psychiatrically hospitalised, as a consequence of criminal proceedings, particularly with regards the specific relationship between their alleged offending and mental illness. Exactly what it is about psychoses, that makes people act in ways that are against the law, and what might need to change to prevent reoccurrences remains unknown. Increased attention is needed to the measurement of recovery, and to the determination of patterns of recovery and deterioration. Little is known, about optimal treatment and maximal treatment response, especially when treatment is considered over time periods. It may well be that maximum treatment response is reached over a relatively short period of time, when the person becomes stabilised on medication, and that this is followed by a plateau, and no additional recovery. If this is true, then the only reason for ongoing hospitalisation, is for social control and policy purposes,

and debate and clarity is needed about the extent to which this might be beyond the brief of the mental health system. Long term hospitalisation can result in institutionalisation, and the loss of effective living skills, and may in some cases contribute to deterioration in the independent social functioning of the individual. A further aspect of treatment that remains largely unstudied, is the impact of hospital management styles and practices. Certain policies and procedures within an organization may clearly assist forensic patients, and it is also possible that, as Menzies (1989) proposed, they may unwittingly contribute to the very problems they are attempting to solve.

5.4.6 Clinical decision making

There are many aspects of decision making, and points in the process of the hospitalisation, when decisions are made, that could usefully be elucidated. This particularly applies to entry and exit points in the mental health system. Little is known about the extent and manner in which beliefs, attitudes and interpersonal skills can influence decision making. Cognitive psychology has identified that people make a number of errors in decision making, including the use of heuristics, and relying on illusory correlations. The extent, to which these errors apply to clinical decision making, with regards mentally disordered offenders, requires exploration in New Zealand. Decision making can be improved by learning how to recognise and avoid common sources of error. Monahan (1981) argued that lack of attention to base rates, is an error that is frequently made in making clinical predictions. There is however, very little base rate information currently available in New Zealand. It would be valuable to have information available, particularly about the outcome of patients released from the forensic units of psychiatric hospitals, to enable decisions to be more effectively made about the probability of success. New Zealand based normative information is needed to inform decision making.

One of the most important forms of decision making are those which are based on predictions of the likelihood of dangerousness. Disposal options under section 115 of the CJA, 1985, are made with reference to 'public protection', and 'risk of harm to others' is a justification for the continuation of special patient status. The MHA, 1992 also specifies risk of harm to the

person themselves or others, as parameter for consideration in decisions with regards compulsory treatment. Containment within the mental health system therefore, is frequently dependent on the presence of mental disorder, and judgements about the risk of reoffending, and other dangerous behaviour. Little is known about how these decisions are reached, and the related issues of establishing public confidence in decreased risk, and determining the level of risk that is acceptable by society.

Most of these decisions appear to be made on a clinical basis, and both the judiciary and the mental health system in New Zealand, seem to have paid only scant attention to the clear empirical finding that actuarial decision making has consistently been shown to be superior to clinical decision making (Meehl, Cicchetti, & Grove, 1991). The empirical investigations, reported by Monahan and Steadman (1994b) have clearly demonstrated that compared with the risk associated with substance abuse, and the combination of being young, male, and of low socio-economic status, the risk associated with major mental disorder, such as schizophrenia and affective disorder is small. Violence amongst those with a mental disorder is most often caused by the same factors that cause it in others, for example being threatened or excess substance use. The extent, to which these established risk factors are systematically taken into account in the prediction of violence, amongst mentally disordered offenders and related decision making, is not known and warrants research.

It is hypothesised that clinicians working in the forensic area, when faced with decisions about the risk of future violence, pay more attention to the current mental status of the individual, than to the empirical established risk factors of being male, young, poor, and a substance abuser. This is likely because mental status assessments and diagnoses are what they are most familiar with, and have a higher degree of potency. There may well be excessive reliance on diagnosis as a predictor of dangerousness, to the exclusion of predictors that apply to all individuals, whether they are in the mental health system, the criminal justice systems, or remain as part of the general population. Further research identifying valid predictive relationships is vital. A research

possibility might be, tracking the decision making within the review tribunals or by responsible clinicians with regard dangerousness, initially using qualitative methodology on an exploratory basis, with latter refinement to quantitative investigation. Study would be particularly interesting, into the decisions made with regards people who commit serious crimes, such as murder and are found to be legally insane, yet quickly stabilise on medication, such that their ongoing risk of dangerousness is low. If political reasons are the justification for the ongoing containment of these people in the mental health system, as is hypothesised, then this would become explicit.

The criteria for community discharge, while undoubtedly reflecting some perception of stabilisation of mental status over time, and reduction in propensity for violence and recidivism are not clearly delineated. It is not known how much stabilisation of mental status is necessary and how this relates to other critical variables such as dangerousness, and ability to either adequately or happily survive in the community. It may be that decisions about community release are influenced more by issues such as the availability of suitable placements, which is a resource issue, than assessments of the persons ability to cope with community placement, or reductions in risk levels. More normative data are needed about the criteria for community discharge. Eisner (1989) described of a scale to determine the 'readiness' of insanity acquittees for community placement. This scale included items in the following areas: illness; behaviour; substance abuse; treatment attendance; medication; self awareness; signs of illness; lifestyle adjustment; relationship of illness to crime; acceptance of responsibility for crime; and acceptance of release conditions. It does not focus on the issue of dangerousness, which Eisner regards as a separate consideration. While this scale remains experimental, the development of instruments such as these in New Zealand, would provide a tool to usefully describe existing practices, and with which to make comparisons with the practices in other countries. Scales such as this one might be useful also in helping ensure standardisation of the decisions, with regards community placement.

Further clarity is needed with regards to the issue of determining success in the community, following discharge. The criteria of success requires operationalisation beyond the reduction in recorded recidivism, and future psychiatric hospitalisation. It could be expanded to include unreported crime, and other forms of dangerous behaviour, such as threats of harm, that might have a high impact on the victim, yet do not lead to criminal charges being laid. Other factors that might be relevant, in specifying success include stabilisation in mental state, and community adjustment, for example, the suitability of housing, employment, social and intimate relationships, and useful employment or occupation, whether paid or not. The perceptions of the individual, and his or her family are also relevant. It would be important to keep goals realistic, and in some cases success might be implied, by lack of deterioration. Scales such as that developed by Quinsey et al. (1988) attempted to identify the community adjustment problems of forensic patients, while requiring investigation with regards the extent of generalisation to New Zealand, would be particularly useful in this task. Research could potentially identify the extent to which factors, such as those identified by this scale, are related to success, or lack of success. This would yield valuable information about important intervention goals. Natural recycling frequently marks major mental illness, and periods of exacerbation followed by periods of relative stability. There is much to be learnt about the prediction and external and self management of acute episodes, and how this relates to community success. More information is needed also about the process of community follow-up, and the extent, and manner with which it possibly reduces recidivism, and contributes to community success.

5.4.7 Psychopathy

Further study is also warranted into the concept of psychopathy. It is of relevance, in that psychopathy has been shown to be a robust predictor of violence and violent recidivism amongst both the criminal population, and mentally disordered offenders, where the base rate of psychopathy is most likely relatively low (Hill, Rogers, & Bickford, 1996; Webster, Harris, Rice, Cormier, & Quinsey, 1994). It is also of relevance, in that many of those referred to in the current study as the vulnerable, those who were psychiatrically assessed yet were not hospitalised, are likely to have features of psychopathy. The independent status of psychopathy as a separate syndrome requires further verification, particularly with reference to the legal, personal and social consequences for the individual. Given the piece in the jigsaw that psychopathy plays, particularly in terms of the risk of dangerousness that accompanies the construct, further study is urgently needed.

A start to research in this area, would be establishment of the base rates of psychopathy within the psychiatric population, with special reference to forensic patients. It would be valuable to then relate psychopathy with recidivism, and to compare any association found amongst psychiatric patients, with that found amongst people sentenced within the criminal justice system. This would help explore the relationship between mental illness, psychopathy and recidivism. I together with Jo Mulligan, have such a study underway.

While psychopathy is no justification for the insanity defence, disability, hospital orders under section 118 CJA, 1985, or compulsory assessment and treatment, individuals with this disorder do feature amongst the psychiatric population. This is most likely because of comorbidity with mental illness, and when mental illness is treated with medication, or goes into remission or a less florid phase, psychopathic features become more apparent in some individual's functioning. The literature with regards the treatment of psychopathy, is marked by the poverty of available information and there are few well controlled studies. Milieu therapy has however been frequently regarded as the treatment of choice (Dolan & Coid, 1993; Meloy, 1995). Osran and

Weinberger (1994) recommended that the focus of intervention should be on the symptoms of the personality disorder that directly relate to their risk of harm, such as anger management, and substance abuse treatment, and on those features which contribute to the exacerbation of major mental illness. The treatment of psychopathy represents a vital but major challenge, to both clinicians and researchers, in both the mental health and the criminal justice spheres. The Law Commission (1994) recommended that the criminal justice and mental health systems, work together to establish a common understanding, of the circumstances in which personality disorder may fall within the statutory definition of mental disorder. It can be argued that this sentiment should be extended to include the development of effective treatment programmes. Some precursors of this are currently occurring in New Zealand, in that the role of mental health system input is being explored in the area of the development of policy on the management of offenders with personality disorders.

5.4.8 Public attitudes

While it is clear from the research discussed above (chapter 1.1.5) that many myths are held about the insanity defence in America, the extent to which they are held in New Zealand, is unknown. Brookbanks (1996b) proposed that they are less strongly held in New Zealand, however, he argues this without empirical verification. There are less controversial and highly published insanity trials in New Zealand, but there is public concern about offending by mentally disordered offenders. The extent, to which this public concern reflects media distortions, is unknown and warrants study. It would be useful to know more about the role the media in New Zealand plays, in contributing to public perceptions of both the nature of mentally disordered offenders, and their realistic risk of reoffending. This could be done by comparing media reports of offenders, with and without a mental disorder, and examining the emphasis of the reports.

While it is questionable whether that there are less myths about the insanity defence in New Zealand, a related issue is the extent of fear of insanity and mental disorder, that is held by the New Zealand general public. Horrific crime is occurring at an increasing rate in New Zealand,

and to label such crime as being because of madness may provide a palatable explanation for the lay person. However, this may be erroneous, in that most of the extreme and horrible crime that New Zealanders are concerned about, is probably committed by offenders who have psychopathic traits, rather than by those who are insane or mentally disordered, using the current legal definitions. A study of public attitudes and opinions with regards the insanity defence would assist the understanding of the social construction of insanity and madness, within the New Zealand context.

5.4.9 Qualitative research

Many of the ideas for future research discussed thus far, are based on quantitative methodologies. Qualitative methodologies however, also have much potential, particularly with regards identifying themes and attitudes. During the current study, the police summaries of facts were consulted at times. These reports contain rich and colourful portrayals of some interesting perspectives, both on the concept of insanity, and expectations with regards to the mental health system. It would be interesting to give the various players in the criminal justice, mental health interface, such as lawyers, and nurses, vignettes and words that were designed to elicit their constructions of madness. These could be compared between occupational groups.

Qualitative methodologies also would be useful in portraying the human experience that is not always apparent, when studying groups of people. Being involved at the criminal justice, mental health interface is often a time of crisis and despair for many individuals, and their families and friends. For others it can bring considerable relief. Individuals are faced with monolithic and powerful systems that can have extreme influences on their lives. Whilst within these systems, people lose more of their human rights, than in any other sphere of life. People likely feel powerless, and ignorant, because the complexities are extreme, particularly for those unused to them.

Janet Frame's autobiographical novels (Frame, 1989) portraying some of the absurdities accruing in psychiatric hospitals, in the 1950s and 1960s, in New Zealand has had a powerful

influence on the collective social understanding, with regards the functioning of psychiatric hospitals. The individual experience of people in forensic units in the nineties needs also to be recorded, and is likely to provide some useful insights that might lead to improvement in management practices. The impact of medication, for example, would be interesting to study. While it is important in the management of psychosis, it appears to leave many people drowsy, unable to think clearly, or to feel that they are their true selves. Replication of the work of Menzies (1989) in New Zealand would also be valuable in that it implies that the system in some ways creates the very deviancy, that it is attempting to treat, and in a subtle manner knowledge is manufactured.

5.5 SUMMARY OF RESULTS

In the current study, only a small number of defendants become hospitalised as a consequence of their court appearance. About 20% of defendants that the CLN screened had been seen previously, which suggests that a group of repeat offenders have noteworthy mental health difficulties.

Referrals to the CLS, came from a wide range of sources, and were made for a variety of reasons. Most referrals come from solicitors and the police. The police referred more of those who received a psychiatric report, compared with other agencies.

Most defendants who were referred to the CLS were male. There was a suggestion that females may be over represented, amongst those referred to the CLS, relative to the prison population. It may be, however, that this is explained by the fact that while, about one in four of police apprehended offenders is female, they face less serious charges. People of Maori descendant were under represented amongst those that were referred. It is possible that these ratios are related to the likelihood of referral agencies seeking mental health etiologies, to explain offending with these groups of defendants. Court liaison referred defendants were older than the prison population, and those who received a report were older than those who did not. There may be some interaction with ethnicity, in that the population of Maori people is younger than the population of Pakeha people.

Criminal defendants referred to the CLS were profiled by social disadvantage. They were infrequently married, or in employment, had poor accommodation arrangements, and appeared to be of low socio-economic status, and education. This is a robust finding that occurs across jurisdictions. Few differences were found in the other demographic characteristics, between the group that received a report and the group who did not, and between the group who were hospitalised, and the group who were not. This is likely because of the high base rates of factors, reflective of social disadvantage. Most defendants referred to the CLS had a history of prior conviction, and they faced charges relating to all types of crime. Most defendants referred

to the CLS also had a history of prior mental health treatment. Unsurprisingly this was greater amongst the group who received a report, and amongst the group who were hospitalised.

The victims of those who were psychiatrically hospitalised compared with those who were not, were more often male, and less often domestically involved with the offender. This suggests some important differences in the dynamics of their offending.

About half of all defendants referred to the CLS acknowledged difficulties with alcohol and/or drugs, which is likely to be an underestimation. Half of all defendants in the current study, acknowledged difficulties with alcohol and/or drugs. About a third were under the influence of alcohol and/or drugs, at the time of the alleged offending. Further provision of treatment resources in this area was proposed.

A group described as the vulnerable were identified. These were defendants who had received a psychiatric report, but were not hospitalised. They have considerable mental health needs. This group was more often referred because of concerns about dangerousness, were more likely to have been using drugs and/or alcohol at the time of the crime, and were rated as showing more evidence of family conflict, depression and as being at greater suicide risk. It was advocated that greater attention be played to providing treatment services to this group.

The mental status screening was shown to be a useful tool in discriminating both between the group who received a report and the group who did not, and between the group who were hospitalised and the group who were not.

Those defendants, who were hospitalised as a consequence of their court appearance, most often had diagnoses of schizophrenia, bipolar affective disorder or unspecified psychoses. These diagnoses however, were made amongst some of those who were not hospitalised. Defendants who were not hospitalised more frequently had diagnoses of depression, substance abuse or dependency and antisocial personality disorder.

Both report and hospitalisation were able to be successfully predicted using the information collected at the time of the CL screening, particularly mental status information and

psychiatric history. The addition of diagnosis as a predictor variable resulted in an improvement in the correct prediction rates of those who were hospitalised, but not those who were not hospitalised. Diagnoses alone was able to predict eventual outcome as efficiently as a combination of variables. This is likely because it is a higher order construct that subsumes much of the other information.

5.6 CONCLUSIONS

- (1) Both insanity and mental disorder, are social constructions that are the product of history, morality, social science, the law, and publicly held myths. There are difficulties in using psychological phenomena to make judgements, regarding fundamentally moral and ethical issues, about constructs such as insanity and disability. Studies can do little more than identify factors that are reliably associated with these decisions, with their ultimate validity remaining unknown.
- (2) The CLS plays an extremely valuable role, in identifying and screening defendants, who may meet the current criteria for psychiatric hospitalisation. The statistical model used in this study, based on variables extracted from the CL records, accurately predicted outcome, particularly amongst those who were not hospitalised. A greater role is advocated for the CL staff in the decision making, with regards to who is recommended to the court for psychiatric hospitalisation.
- (3) Most criminal defendants who are referred to the CLS, are socially disadvantaged, regardless of their entry or not to the mental health system. The current study suggested that people of Maori descent may be under represented and females over represented amongst those defendants who are screened by the CLN, relative to the prison population. The implication of this is that special care and attention, is needed when assessing people with these characteristics.
- (4) The people in this study who were psychiatrically assessed, but did not meet the criteriion for hospitalisation, make up a group who are vulnerable, and have considerable mental health needs, and it is recommended that they receive increased resources, and attention.

- (5) It seems likely that paternalistic concerns to protect mentally disordered offenders and to ensure perceived treatment needs are met remain paramount, and that what victims might require to resolve the matter is seen to be beyond the parameters of the legal system. Increased attention to the victim's perspective is recommended.
- (6) The insanity defence is essentially an historical artifact that exists in order to define the limits of our moral judgements. It represents an extreme on a continuum, and is thus important in delineating values and justifying the imposition of punishment. The concept has minimal usefulness, however, in terms of the effective assessment, and treatment of mentally disordered offenders. It is advocated that section 118 CJA, 1985 hospital orders, also be abolished, and that development continue using other factors, such as treatment options to define admission criteria. The concept of disability is more difficult to abandon, given that it is a fundamental right that each individual receives a fair trial. In the current New Zealand context, it requires refinement however, especially with regards the unsuitability of psychiatric hospitalisation for intellectually disabled people.
- (7) While this study has explored the entry point to the mental health system, via the courts, consideration of exit points is vital also. Further clarity is needed with regards to the social containment function of psychiatric hospitals, and when they are working as handmaidens of the criminal justice system, in that their purpose is containment rather than treatment.
- (8) Ongoing research and theory development is imperative. Interdisciplinary approaches are likely to be particularly fruitful. The disciplines of social science and law, have developed in relative isolation, only meeting in the court room to decide the outcome for individuals, and a closer relationship, while requiring clarification of values, it is likely to advance understanding. Psychologists have a critical role to play in understanding the interface between the mental health and the criminal justice system.

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APPENDIX 1

REGIONAL FORENSIC PSYCHIATRIC SERVICE

COURT LIAISON

ASSESSMENT SHEET

Surname _____ First name/s _____

Address _____

Date of Birth _____ Age _____ Sex Male _____ Female _____

Phone No. Home _____ Race _____

Country of Birth _____ Years in NZ _____

Relationship status:
Married _____ Single _____ Parted _____ Widow _____ Other _____

Assessor _____ Date _____ Previous contact Y N

Referral source _____

Reason _____

Charge/s _____

Counsel _____

Employment status:		
Self employed	Paid employment	Unemployed
Sickness	Retired	Homeloduties
Voluntary worker	Student	Other

Occupation _____

Source of income:		
Employment	Parents	Partner
Friend	Benefit	Other

Current accommodation _____

Education/Work record _____

Family network _____

Mental State Examination:

- 1 General behaviour, appearance, and attitude
 - Facial expression, level of activity and awareness
 - Tics, mannerisms
 - Compulsiveness or ritualistic behaviour.

- 2 Mood
 - Depressed, normal, elated, congruous or incongruous.

- 3 Talk
 - Free or constrained - to the point or not
 - Sudden silences
 - Neologisms, puns, derailment, circumstantiality, tangentiality
 - Loss of goal.

- 4 Thought form and content
 - Rapid or retarded
 - Delusions of persecution, grandeur, poverty, misinterpretation
 - Thought blocking or broadcasting
 - Insertion or withdrawal
 - Obsessional thinking.

- 5 Orientation
 - Time, place and person
 - Attentive and concentration

- 6 Perception
 - Hallucinations of sight, sound, touch, smell, hearing
 - Peculiar sensations.

- 7 Memory
- Any evidence of short or long-term impairment.

8 Insight

9 Suicide

Forensic history

Medical history

Psychiatric history

Alcohol/Drugs

Summary

Recommendations

Outcome

Offence Categories

V	S	OP	U	W	FF	DR	GO
DE	A	FO	X	J	L	T	

APPENDIX 2

REGIONAL FORENSIC PSYCHIATRIC SERVICE
COURT LIAISON

RECORD OF OUTCOME

NAME _____

ADDRESS _____

D.O.B. _____ AGE _____ COURT APPEARANCE DATE _____

CHARGE/S _____

RECOMMENDATION _____

JUDICIAL OUTCOME _____

SUMMARY _____

APPENDIX 3

Variable categories: Decision rules and explanatory notes

Most include an unknown category which was used when the information was not assessed or recorded or was unknown for any other reason.

1. Year

- i) 1992
- ii) 1993
- iii) 1994

This referred to the date of the assessment.

2. Previous contact

- i) yes
- ii) no
- iii) unknown

Previous contact with the RFPS was coded at the time of the screening assessment by the CLN.

3. Referral agency

- i) duty solicitor
- ii) counsel
- iii) police
- iv) probation
- v) judge
- vi) Sunnyside
- vii) family
- viii) other
- ix) unknown

Duty solicitors (category i) differ from counsel (category ii) in that they are court appointed and paid for by legal aid. Category iii) included both police officers involved in the apprehension of the alleged crime and the police prosecutor at court. Category iv) included referrals from probation officers and a small number from prison staff. Referrals from Sunnyside staff (category vi) included those defendants who had been seen previously by the RFPS and

those referred by staff in other parts of the hospital. Self referrals and those by other family members were included in category vii). Category viii) was a miscellaneous one and included referral from people like social workers, and general practitioners and from agencies such as the Salvation Army.

4. Referral reason

- i) history
- ii) mental state
- iii) nature of the charge
- iv) presentation
- v) dangerousness
- vi) psychiatrically unwell
- vii) fitness to plead
- viii) recidivist
- ix) other
- x) unknown

Those defendants in category i) or their families had had previous contact with Sunnyside. Category ii) was a general one and included statements like 'seems unwell mentally', 'may be depressed' and 'concern for the defendant.' Category iii) was used when something about the nature of the charge prompted referral, such as assault on a child, breach of nonmolestation order, or an armed defenders callout. Concerns about the subject's presentation were coded in category iv). Examples included the defendant having his face painted, and excessively loud and disruptive behaviour at court. Dangerousness either to the defendant him or herself, or others, was the referral reason in category v). Category iv) included requests for the assessment of the possible presence of mental illness that may have influenced the judicial outcome. Category vii) was used when there were queries specifically related to the possibility of disability, for example, 'doesn't seem able to follow instructions'. When repeat offending was the stated reason for referral category viii) was used. The miscellaneous category ix) included family requests, and the occasional question directly from the judge, with regards matters such as the defendants suitability for bail, or to determine whether the defendant was intoxicated or suffering from cerebral palsy, as he claimed.

5. Gender

- i) male
- ii) female

6. Age

Age was recorded in years, at the time of assessment.

7. Ethnicity

- i) Pakeha
- ii) Maori
- iii) Pacific islander
- iv) unknown

Ethnicity was determined by the CLN. In cases of doubt defendants were asked their race. Subjects of mixed blood, were asked which race they most identified with.

8. Relationship status

- i) single
- ii) separated
- iii) married
- iv de facto
- v) unknown

Categories i) to iii) were noted at the time of assessment by the CLN. The category of de facto was included at the time of data collection, because of the large number of subjects whose relationship status was of this nature. Because of the small number of widowed defendants, they were included in the separated category.

9. Accommodation

- i) own family
- ii) family of origin
- iii) flatting
- iv) boarding
- v) institution
- vi) no fixed abode
- vii) unknown

Category i) included all those who were living within a family that they had established.

Statements such as 'married', 'has three children' or 'living in own home' were coded in this category. Defendants coded in category ii) were living with their family of origin including parents and extended family, such as siblings and aunts. Defendants who were living with friends, flatting or renting, were coded in category iii). Category iv) boarding, included reports of defendants living in the homes of other people for money, hotels, and bedsits, as well as places such as the City Mission, or halfway hostels. Defendants coded in category v) institution, were living in prison, or places like Kingslea, or Sunnyside Hospital, at the time of the court appearance. Category vi) no fixed abode, included camping grounds.

10. Employment status

- i) employed
- ii) unemployed
- iii) sickness beneficiary
- iv) other
- v) unknown

Defendants coded in category i) were in paid employment at the time of the assessment. Defendants coded in category ii) were unemployed. Category iii) included all those who were on a sickness, invalids, or disability allowance, or who were living on Accident Compensation Corporation payouts. Homemakers, retired people and students were included in category iv), other.

11. Criminal history

- i) yes
- ii) no
- iii) unknown

Category i) was used when there was at least one previous conviction recorded.

When there was a record stating that the defendant had no history of previous convictions, category ii) was employed.

12. Crime type

- i) violence
- ii) property
- iii) sexual
- iv) crimes involving weapons
- v) driving
- vi) State
- vii) drug
- viii) other

In cases of multiple charges the most severe charge was used in coding crime type.

Category i) included crimes where violence was involved, with or without weapons. Various forms of assault, wounding with intent, grievous bodily harm, aggravated robbery and wilfully ill treating a child were included in this category, as were intimidation and threats. Category ii) included non-violent property crimes, and those of dishonesty. Crimes such as fraud, false pretences, wilful damage, arson and trespass were included in this category. Category iii) included crimes of a sexual nature either against children or adults. Category iv) included crimes where there was possession of an offensive weapon, such as a gun or knife, but no actual violence had taken place. Examples included 'reckless discharge of firearm' and 'intoxicated in charge of firearms'. Category v) included driving offences, for example, 'driving with excessive breath alcohol', 'driving while disqualified' and 'careless use of a motor vehicle'. Category vi) included crimes against the State such as 'breach of bail or non-molestation', 'resisting arrest', and 'escaping from an institution'. Category vii) was used when the alleged crime involved drugs of

any type. Category viii) was a miscellaneous category and was used for crimes such as 'misuse of a telephone', 'obscene language' and 'cruelty to animals'.

13. Victim's gender

- i) male
- ii) female
- iii) unknown

Where there was more than one victim, the gender of the complainant was coded.

Category iii) was used where there was no direct victim, for example, 'stealing from a supermarket', 'breach of periodic detention', and 'traffic offences'. It was also used when victim information was unknown.

14. Victim type

- i) domestic
- ii) non-domestic
- iii) unknown

Category i) included all family members, partners, and ex-partners. Also coded in this category were people such as neighbors, flatmates, and caregivers. Category ii) included cases where a victim was identified, however they were strangers or acquaintances, for example, employers, baby sitters or policeman. Category iii) was used when there was no direct victim or the information was unknown.

15. Family support

- i) yes
- ii) no

If there was any evidence of family support in the record, category i) yes, was used, for example, 'close contact', 'good relationship with family'. Also included were notes of the presence of support people at court. Where there was no indication of family support category ii) no, was employed. Information describing the number of family members, family composition or

where the family lived was not coded. It was not assumed for example, that because a defendant lived with his wife that this was evidence of support.

16. Family disruption

- i) yes
- ii) no

Any evidence of family disruption or trauma was coded i) yes. Examples included 'separation from partner or family of origin', 'conflict', 'disruptive childhood', 'abuse', 'parental psychiatric history, or death'. If there was no indication of familial disruption category ii) was used.

17. Psychiatric history

- i) inpatient-current followup
- ii) inpatient-previous
- iii) outpatient-current followup
- iv) outpatient previous
- v) counselling
- vi) emergency contact
- vii) previous report
- viii) suggestions
- ix) no known past history
- x) unknown

Within all of the categories drug and alcohol treatment was included in the definition of psychiatric treatment. Category i) referred to defendants who had been inpatients at a psychiatric hospital and were being followed up by mental health services at the time of the alleged offence. Category ii) referred to previous inpatient admission at a psychiatric hospital, but without psychiatric follow up at the time of the alleged offence. Category iii) included those defendants who had outpatient status with a psychiatric hospital or service at the time of the alleged offending, but had never been admitted to a psychiatric hospital. Category iv) included defendants who had had previous outpatient contact with a psychiatric hospital or service, including assessment. Those in category v) were in counselling at the time of the alleged offence, or had attended a course such as an anger management programme, or had done so previously.

Category vi) was employed when the defendants had been seen recently by the Psychiatric Emergency Service or had other emergency contact. Category vii) was used when a previous psychiatric report for the court was recorded, and this was the only known psychiatric history. Category viii) referred to suggestions of past psychiatric disorder, for example, 'prescribed antidepressant medication by general practitioner'. Category ix) was used when it was noted that there was no known psychiatric history.

18. Alcohol and/or drug history

- i) difficulties - treatment
- ii) difficulties - no treatment
- iii) noteworthy
- iv) no
- v) unknown

Acknowledged difficulties with alcohol and/or drugs and previous treatment for this were coded i). Category ii) was used when alcohol and/or drug difficulties had been noted, but there had been no known treatment efforts. Category iii) was employed where there were suggestions of difficulties but no clear acknowledgment by the defendant, for example, alcohol usage at the time of the alleged offence. If there were no apparent difficulties with alcohol and/or drugs, category iv) was used.

19. Alcohol and/or drug type

- i) polysubstances
- ii) alcohol
- iii) marijuana
- iv) narcotics
- v) solvents
- vi) prescription medication
- vii) none
- viii) unknown

Category i) included statements, which referred to the use of more than one substance, for example, 'drugs', 'alcohol and drugs', 'marijuana and alcohol'.

20. Alcohol and/or drugs at the time

- i) yes
- ii) likely
- iii) no
- iv) unknown

Category i) included definite reports of alcohol and/or drug usage by the defendant, at the time of the alleged crime. Category ii) was used when it seemed likely that there was drug and/or alcohol usage, but no definite reports were made, for example, 'was known to be a heavy drug user', or the police suggested alcohol and/or drug involvement in their summary of facts. Category iii) referred to reports where there was no evidence that alcohol and/or drug usage occurred, at the time of the crime.

21. Suicide history

- i) yes
- ii) no
- iii) unknown

When there was a recorded history of a suicide attempt or attempts, category i) was employed.

22. Suicide risk

- i) low
- ii) moderate
- iii) high
- iv) unknown

Category i) was employed when the suicide risk was rated to be low, or none. Category ii) was used when the risk was regarded as moderate, or low to moderate. This included defendants who had suicidal ideation, but had not clearly developed a plan. Category iii) referred to ratings of high, and moderate to high suicide risk. It included defendants who had definite suicidal ideation and a suicidal plan.

23. Behaviour

- i) appropriate
- ii) dysphoric
- iii) angry
- iv) agitated
- v) anxious
- vi) perplexed
- vii) noteworthy
- viii) unknown

The most prominent behavioural observation was coded. In category i) no noteworthy behaviour was observed during the assessment. Category ii) referred to behavioural manifestations usually associated with low mood, such as 'tearfulness' or 'looking downcast'. Category iii) included behaviour such as 'pacing up and down' and 'excessive distress'. Category iv) was employed when defendants were described as 'shy' or 'fearful'. Category v) included loud and abusive behaviour as well as that which was described as 'threatening' or 'intimidating'. Defendants coded in category vi) did not seem to comprehend the situation. Category vii) included a range of other unusual behaviours, such as the defendant who stood with his hands on his ears, or the man stood with his back to the assessor. Most often this category was used to describe unusual nonverbal behaviour.

24. Appearance

- i) appropriate
- ii) dishevelled
- iii) disability
- iv) weight
- v) intoxicated
- vi) ill
- vii) noteworthy
- viii) unknown

Category i) was used when there was nothing noteworthy about the defendant's appearance. Observations of considerable untidiness, and/or unclean smell, were coded in category ii). Physical disability such as the defendant being in a wheelchair, or obvious severe visual impairment were coded iii). Category iv) was used when comments were made about weight, either excess overweight or extreme thinness. Category v) was used when there were signs of recent intoxication. Defendants who impressed the assessor, as appearing unwell, for example, 'covered in eczema' or evidence of recent injury which was often crime related, were coded vi). Category vii) was a miscellaneous category used to describe something noteworthy or unusual in the defendant's appearance, and not falling within other categories, for example, 'dressed totally in white' or 'multiple facial tattoos'.

25. Engagement

- i) satisfactory
- ii) difficult
- iii) uncooperative
- iv) unknown

There was no specific place for this information to be noted on the Court Liaison Assessment Sheet (Appendix 1). However it was coded because comments about engagement were often recorded. Category i) was used when the engagement process was regarded as satisfactory. Category ii) was used when any descriptions of difficulty in engagement were noted, for example, 'not willing to talk' or 'guarded in replies'. Category iii) referred to those screening assessments when the defendant was extremely uncooperative or refused to answer assessment questions.

26. Mood

- i) appropriate
- ii) depressed
- iii) angry
- iv) anxious
- v) elevated
- vi) unknown

Mood was assessed by direct questioning and observation, and the most prominent mood state was categorised. Category i) was used when mood appeared appropriate to the situation, and no abnormality, or extremity of mood was noted. Category ii) referred to suggestions of depression or dysphoria. Category iii) was used when the defendant said that he or she felt particularly angry, or appeared to be so. Category iv) was used when there were observations or reports of marked anxiety. Category v) included elevations of mood, and also mood incongruity, and lability.

27. Thought form

- i) satisfactory
- ii) constrained
- iii) pressurised
- iv) noteworthy
- v) unknown

Thought form and thought content were coded from the information provided on the Court Liaison Assessment Sheets (Appendix 1) with regards to talk, thought form and content. Category i) was used when nothing unusual was observed in the defendant's thought form. Comments such as 'retarded' or 'excessively quiet', were coded in category ii). When thought or speech was described as pressurised, category iii) was used. Any other observations were coded in category iv) noteworthy. This included over inclusive speech, loss of goal and loose associations.

28. Thought content

- i) satisfactory
- ii) delusional
- iii) stressors
- iv) noteworthy
- v) unknown

Category i) was used when the defendant's thought content appeared to be within normal limits. When delusional thought content was noted, or the possibility raised category ii) delusional was used. Category iii) was employed when the defendant excessively discussed recent stressors or problems. Noteworthy observations such as 'misinterpretation', 'nonsense' or 'difficulties in comprehension' were coded iv).

29. Perception

- i) satisfactory
- ii) hallucinations
- iii) noteworthy
- iv) unknown

Category i) was used when there was no suggestion of perceptual abnormalities.

Category ii) referred to observations of hallucinations. Category iii) was employed when the possibility of hallucinatory experiences was raised, or there was other unusual perceptual observations, for example, hearing voices which did have the quality of hallucinations.

30. Orientation

- i) satisfactory
- ii) difficulties
- iii) unknown

Category i) was employed when there was no evidence of problems in orientation to person, place or time. Category ii) was used whenever there was any suggestion of difficulties in orientation.

31. Memory

- i) satisfactory
- ii) noteworthy
- iii) unknown

Category i) refers to no noted memory difficulties. Category ii) included reports of specific difficulties, for example, 'concentration', or 'blackouts', or suggestions of these.

32. Insight

- i) satisfactory
- ii) moderate
- iii) poor
- iv) unknown

When insight appeared satisfactory, category i) was used. When insight was regarded as moderate, for example, 'some insight', category ii) was employed. Category iii) included statements such as 'poor' or 'limited insight'.

33. Report recommended

- i) inpatient
- ii) outpatient
- iii) penal
- iv) either
- v) no
- vi) unknown

Category i) was employed when it was recommended by the CLN that the defendant be remanded for inpatient psychiatric assessment at Sunnyside (s. 121 (2) (b) (ii) CJA, 1985). Category ii) was used when it was recommended by the CLN, that the defendant be remanded on bail for psychiatric assessment on an outpatient basis (s. 121 (2) (a) CJA, 1985). Category iii) referred to recommendations that the defendant be remanded for psychiatric assessment in penal custody (s. 121 (2) (b) (i) CJA, 1985). Category iv) was employed when psychiatric assessment was recommended by the CLN, however a location was not specified. When further psychiatric assessment and report was not recommended, category v) was employed.

34. Court ordered report

- i) inpatient
- ii) outpatient
- iii) penal
- iv) no

Category i) was used when an inpatient assessment and report was completed. It also included occasions when a penal or outpatient assessment subsequently led to an inpatient admission assessment. Category ii) included outpatient psychiatric assessments and report. When psychiatric assessment was completed while the defendant was in prison, category iii) was used. When no psychiatric assessment was ordered, category iv) was used.

35. Outcome

- i) insanity
- ii) disability
- iii) s 118 CJA, 1985
- iv) charge withdrawn ñ compulsory treatment order
- v) charge withdrawn ñ voluntary inpatient treatment
- vi) charge withdrawn ñ community intervention
- vii) charge withdrawn - other
- viii) prison sentence
- ix) community sentence
- x) diversion
- xi) transfer
- xii) acquitted
- xiii) suicide
- xiv) unknown

The most severe outcome was coded, for example, '7/52 imprisonment followed by STOP' was coded in Category viii). Category i) insanity, was employed when defendants were found to be insane under section 23 of the Crimes Act, 1961. When defendants were found to be under disability under section 108 CJA, 1985 category ii) was employed. Category iii) was used when a hospital order was made under section 118 CJA, 1985. Defendants in this category were guilty and mentally disordered. When the charge was withdrawn and a compulsory treatment order made under the MHA, 1992, category iv) was employed. Also included in this category were a few defendants who were made committed patients under the earlier Mental Health Act,

1969. Category v), charge withdrawn ñ voluntary inpatient treatment, referred to cases where charges with withdrawn and the person agreed to voluntary inpatient hospitalisation. In cases where charges were withdrawn and the person voluntary commenced a community intervention programme, such as attending counselling category vi) was employed. All other cases where the charge was withdrawn, for example 'insufficient evidence', were categorised vii). Category viii) prison sentence, included all prison sentences regardless of length, and included corrective training. Category ix) community sentence, included all community based sanctions such as fines, supervision, reparation, and also suspended prison sentences. Category x) was used when defendants were diverted from the court and required to complete some form of community service. No charge was entered on their record. Category xi) referred to cases where proceedings were transferred to another court. Category xii) was employed when the defendant was acquitted and category xiii) when the defendant committed suicide.

36. Diagnoses

- i) schizophrenia
- ii) bipolar affective disorder
- iii) psychotic (unspecified)
- iv) depression
- v) substance abuse or dependency
- vi) antisocial personality disorder
- vii) other personality disorders
- viii) organic impairment
- ix) intellectual impairment
- x) other diagnoses
- xi) none
- xii) unknown

Only the most serious diagnosis was coded. In cases when more than one diagnosis was made, Axis I diagnoses were coded, rather than Axis II diagnoses. For example, bipolar affective disorder would be coded rather than substance abuse or dependency. Substance abuse was coded rather than personality disorder. Category i) schizophrenia, included schizoaffective disorder. Category ii) was used whenever a diagnosis of bipolar affective disorder was made. Category iii) psychotic (unspecified) included statements like 'psychosis of an unknown etiology', 'complex

delusional system' and 'paranoid delusional syndrome'. Depression (category iv) was employed when major depression was identified. Category v) substance abuse and dependency, referred to all types of alcohol and/or drug dependence and/or abuse. When a diagnosis of antisocial personality disorder was made, category vi) was employed. All other personality disorders were coded vii) and included descriptions of difficulty in personality functioning, as well as definite diagnoses. Category viii) was employed when there was evidence of organic impairment, for example, head injury or dementia. Category x) other, was a miscellaneous one and included anxiety related disorders such as post-traumatic stress disorder and somatoform disorders, pyromania and fetishism.

APPENDIX 4

Reliability of Codings

In order to determine whether information, from the CL files could be reliably coded, using the decision rules outlined in Appendix 3, the agreement between two raters was examined. Both were clinical psychologists working in the forensic area and ratings were done independently. Ten files were chosen, on the basis of completeness of information. Concordance rates for the variables in the current study are given below.

Referral agency	90%
Referral reason	80%
Ethnicity	100%
Relationship status	100%
Accommodation status	100%
Employment status	90%
Criminal history	100%
Crime type	100%
Victims gender	100%
Victim type	100%
Family support	100%
Family disruption	100%
Psychiatric history	90%
Alcohol and/or drug history	100%
Alcohol and/or drug type	100%
Alcohol and/or drugs the time	80%
Suicide history	90%
Suicide risk	90%

Behaviour	80%
Appearance	90%
Engagement	100%
Mood	100%
Thought form	90%
Thought content	90%
Perception	90%
Orientation	100%
Memory	90%
Insight	90%
Diagnosis	90%
Outcome	90%

APPENDIX 5

Psychiatric diagnoses

Coding in ordinal form

Primary diagnosis only

1. No diagnosis
 Unknown diagnosis
 Other diagnosis, e.g. anxiety-related disorders

2. Substance abuse and/or dependency
 Personality disorders

3. Depression
 Bipolar affective disorder
 Moderate organic impairment
 Mild mental retardation

4. Schizophrenia

5. Psychosis
 Major organic impairment
 Moderate mental retardation

A rating of 5 was given where there was mention of psychosis in the report. For example, if a diagnosis of schizophrenia was accompanied by a description of acute psychosis a rating of 5 was given.

Using the same system of determining reliability, as described in Appendix 4, the reliability of coding diagnoses was calculated to be 100%